Hartlepool and Stockton-On-Tees Safeguarding Children Partnership

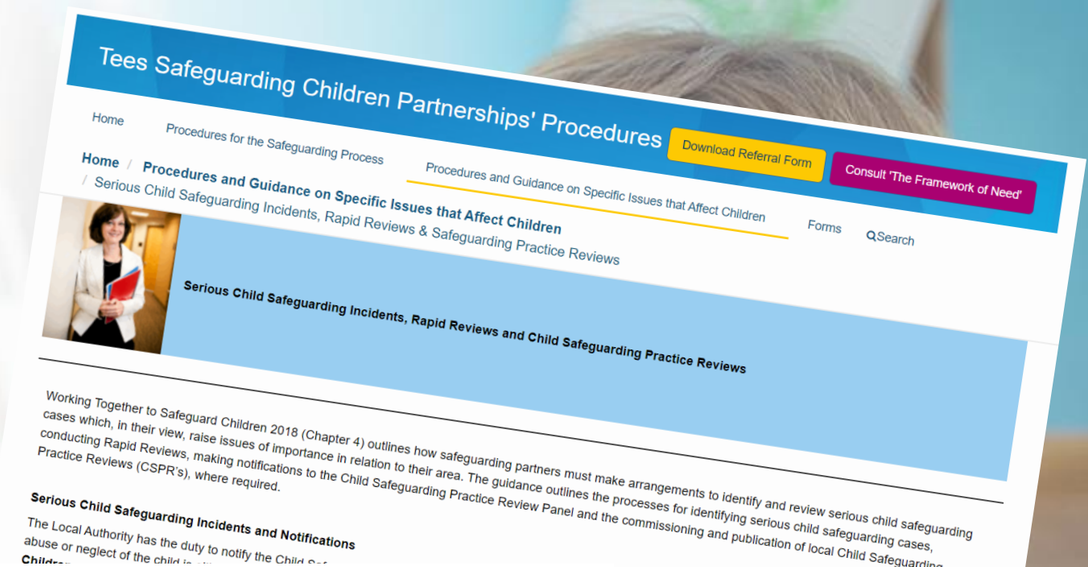
Learning from HSSCP Child Safeguarding Practice Reviews

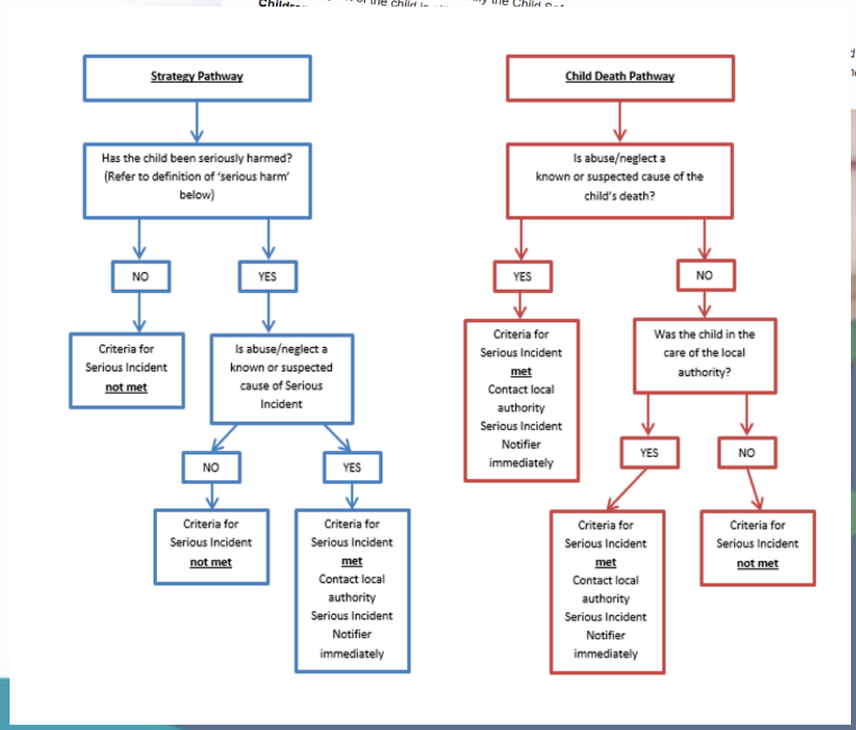
March 2024

Hartlepool & Stockton-on-Tees SAFEGUARDING CHILDREN PARTNERSHIP

Role of the Safeguarding Children Partnership

- Duty for partners to identify serious safeguarding incidents
- Duty for the partnership to undertake Rapid Reviews of serious safeguarding incidents and determine whether a LCSPR needs to be undertaken





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Serious Safeguarding Incident Notifications and Rapid Reviews

- Since going live in early 2019, HSSCP have received twenty Serious Incident Notifications and has conducted a Rapid Review for each of these notifications made.

- Of the twenty Rapid Reviews undertaken, ten have progressed to a Local Child Safeguarding Practice Review.

- One HSSCP LCSPR's has also been part of a National thematic review on NAI under 1's*

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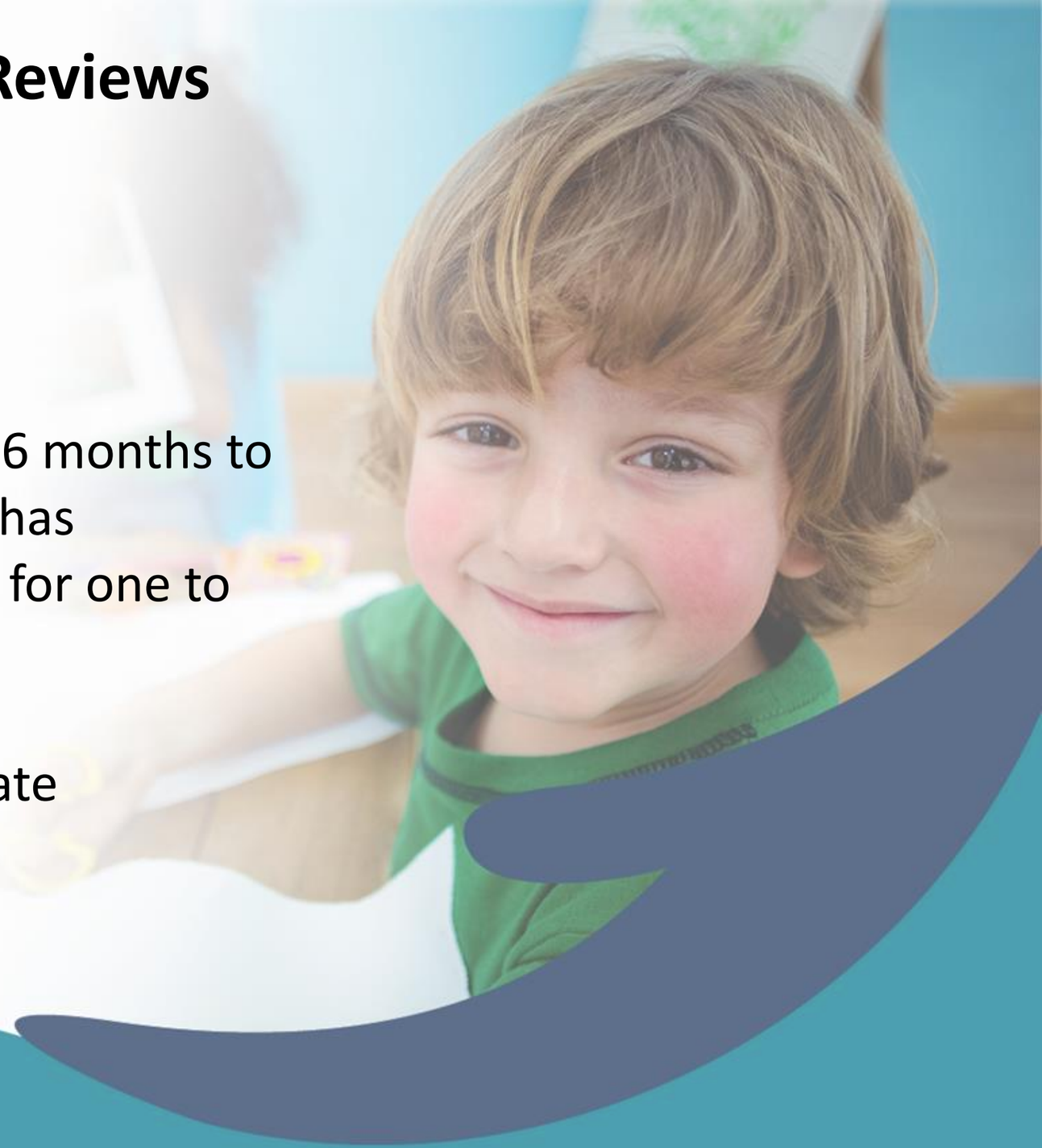
Local Child Safeguarding Practice Reviews (LCSPR's)

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



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60% • 12/20 were children under 3

35% • In 7/20, the child died (6 of the 7 who died were babies).

35% • 7/20 involved non-accidental injury or physical abuse

100% • Neglect featured in all 20 cases and in 9/20 was the **45%** cause of the significant incident or death.

75% • 15/20 featured Domestic Abuse

55% • 11/20 had recently closed to children's social care

70% • 14/20 were Stockton children

30% • 6/20 were Hartlepool children

65% • 13/20 featured hidden fathers or partners

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LOCAL CHILD SAFEGUARDING PRACTICE REVIEWS/ RAPID REVIEWS

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Child JM LCSPR

Context

- Child JM was 17 years old when he was involved in a significant incident.

- In the years running up to the incident, Child JM had had involvement from the Youth Justice Service, Early Help, Children's Social Care and MACE. He had been the subject of a Secure Order and a Full Care Order at age 15, which was revoked at age 16. At age 16, a Community Order was made. At age 17, a 12-month Rehabilitation Order was made and the Care Order had been reinstated. A strategy meeting was held 2 months before the significant incident.

- Historical concerns about Child JM included: neglect, learning needs, parental mental health needs and substance misuse, anti-social behaviour (including threats to peers, shoplifting, fire setting, assault and theft), permanent exclusion from secondary school, involvement with gangs, drug-use, public order offences, missing from education, aggressive behaviour, lack of family engagement, high risk of CCE and death by misadventure, frequent periods of missing, and habitual knife-carrying.

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Findings

- Child JM was not seen as an exploited child and was consistently blamed in the documentation for placing himself at risk and 'choosing' to place himself in danger. His narrative clearly shows indicators of neglect, adversity and harm, and his family was identified to be a 'Troubled Family' in need of support. Chronologies show increasingly severe behaviours and risks, which were compounded by a limited understanding of his cognitive ability and functioning, yet these factors were not raised as concerns. After his Secure placement, efforts were made to progress an EHCP, but this was not accepted and its rejection was not challenged.
- Until JM was in a Secure placement at the age of 15, no concerns were raised about his cognitive ability and functioning, which led to a misunderstanding of his needs. When a cognitive assessment was undertaken, it showed a significant difference between his chronological age and ability.
- Good practice was noted for the referral to Forensic CAMHS upon his leaving his Secure placement; however, it was decided that there was no role for FCAMHS as other agencies were involved and there were no concerns raised about his mental health.
- Child JM's vulnerabilities and ACE's did not seen to inform his referral to CSC, where the decision was made that the family's needs could be met by Early help. It later became clear that Early Help did not have access to Child JM or his family's history due to using a different recording system.
- Good practice was seen from the education inclusion team when they referred Child JM for possible CCE; however, this did not inform the decision to close the case, which was not challenged.
- Professionals felt that all agencies not having access to information was a significant barrier and there was an assumption that other agencies held key pieces of information.
- There are continual comments about a 'persistent lack of engagement', yet Child JM's case was continually stepped down or discharged from services.
- There was reference in the Care Planning documents to a referral to the NRM, but this was never given a timescale or progressed. The opportunity was missed to clearly identify Child JM as an exploited and vulnerable child.

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Learning

- Child JM was not consistently seen as an exploited child and the significance of his pre-disposing vulnerabilities and risks were not appreciated. Child JM had a significant number of vulnerabilities, adverse experiences and developmental issues which made him more vulnerable to grooming and exploitation. With the exception of his stay in Secure placement, limited protection was identified, which allowed his exploitation to continue, causing further trauma and harm. It was identified that there needs to be improvements in the workforce knowledge and skills in recognising and understanding CCE and extra-familial harm.

- Records kept on JM in all agencies featured ‘victim-blaming’ language and suggested that JM chose to place himself at risk. It has been identified that there needs to be stronger professional challenge within agencies if this occurs. It is recommended that agencies consider how they will embed trauma-informed practices within their workforce.

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Child RV LCSPR

Context

- Seven month old RV died whilst sleeping in his cot at home, where he lived with his mother and two older siblings. All three siblings were subjects of interim care orders and were placed at home with their mother and the supervision of a family friend, who was living in the home and was present at the time of his death.
- An exclusion order was in place to prevent RV's father attending the home.
- RV was born prematurely (30 weeks) and remained in hospital for the first 4 weeks of his life. He had fluid on the brain, a large head circumference and a small brain bleed. At 5 months, he was admitted to hospital with poor weight gain and an ultrasound was booked due to an extremely large head circumference. This revealed bleeding around the brain and further exploration was ongoing when the Local Authority implemented a safety plan.
- It was confirmed that the cause of RV's brain bleeds was more than likely inflicted injury and care proceedings were issued with a plan to place the children outside of mother's care. This plan was challenged and an interim care order was agreed with the children remaining in mother's care whilst subject to the supervision and safety plan. An exclusion order was granted to prohibit Father from the address. RV died one week later.

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Background

- Family moved to the area 5 years before RV's birth. Mother had been open to services in another area when her first-born child was adopted from her care and then again when Mother, Father and RV's oldest sibling were open to CSC. They were open under CIN due to domestic violence but closed to social care at the point of transfer.
- Midwifery services made a referral prior to RV's second sibling's birth as Mother disclosed having a previous child adopted from her care, that she has a learning disability and concerns about her family support network. It was decided for Family Hubs to support, but the family did not engage.
- A year later, a referral was made by Sibling 1's school due to concerns around her escalating violent behaviour and Sibling 2's physical presentation. CSC undertook an unannounced visit where home conditions were deemed to be extremely poor. An urgent Strategy meeting was held and a joint visit undertaken which showed significant changes had been made and concluded that the children could remain in the home.
- Two days later, Sibling 1 disclosed that her father had hit her 'all over my body'. A further Strategy was held, another visit to the home was undertaken, a safety plan was implemented and a medical concluded that the two bruises found on Sibling 1 were accidental.
- At the Strategy meeting, concerns were expressed around the cleanliness of the home, Sibling 1's behaviour, parents ability to manage behaviour and Father's drug use. The case proceeded to CPC and the children (including unborn RV) became subject to Child Protection Plans 6 months prior to RV's birth.
- After RV's birth, professionals reported concerns about RV being fully swaddled with his face completely covered, Sibling 1 placing toys around his face in his Moses basket, his low weight, bruises above his eyebrow (caused by Sibling 2 throwing a toy and it landing on him), and Father (who was reported to no longer be living at the address) threatening to burn down the house. RV underwent a Child Protection medical which was inconclusive but suspicious of head trauma. He died one week later.

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Learning from Rapid Review (LCSPR still ongoing)

- A need to adhere to the protocol for management of bruising on non-mobile babies was identified, as this was not strictly adhered to in RV's case and led to a delay in discovering the bleeds on his brain.
- A need was identified for consistent recognition of extreme and violent behaviour as a sign and symptom of abuse and neglect. Whilst this was not the case for RV, his older sibling was consistently displaying this behaviour and it was not always recognised as a form of communication.
- The children in this family were on Child Protection Plans for more that 12 months with very little progress made in that time. The review identified that there is a greater need for professional curiosity as to why the case was not progressing when there was little change in the behaviour of the children and escalating threats and violence from RV's sibling and father.
- Extreme and violent behaviour was consistently displayed from RV's sibling and a need was identified for recognition that they were a victim of abuse and neglect, but also a potential perpetrator of harm towards a new-born sibling.
- Services must ensure that parents with SEND are highlighted to all those working with them and that adjustments are made to ensure understanding by parents and also ensuring the children in their care are safe.
- A recommendation was made for further exploration and understanding of behaviour of victims of domestic abuse, moving away from labelling nondisclosure as disguised compliance.

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HH Rapid Review

Context and Background

- HH (2 months old) was found floppy, pale and unresponsive by her mother on the morning of 28/5/23. She had been sleeping in the double bed with her mother and mother's partner.
- The day before her death, she had been cared for by her uncle while her mother had been socialising with friends. Mother and her partner had both been drinking. Father was not involved with HH.
- Mother had experienced a 'chaotic and disrupted' childhood, spent some time in LA care and had poor mental health which manifested in serious self-harm incidents. Mother and her partner had histories of substance misuse and criminality.
- Unborn HH had been considered at an ICPC but CIN plan was agreed instead due to progress and stability in Mother's life. CIN plan was stepped down to Early Help shortly after Mother moved to Stockton. Mother declined consent for Early Help intervention as she felt she had sufficient familial support. A referral was made to Family Hubs.
- Before HH was born, Mother moved to Stockton from a another local authority and reunited with her family. Family were recorded as being 'supportive' but it was later found that Mother had been emotionally abused in her teenage years by her step-father, who still lived in the family home, and had become homeless at age 15 due to family not being able to manage her behaviours.

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Findings and Learning

- There were opposing views of the family throughout this case. Mother's significant and recent mental health issues were not understood properly and it is felt that there was limited planning for the impact on the baby once born and more focus was given to Mother in the present, who was presenting well. The life of the child was not at the centre of assessments.
- Despite there being significant issues with Mother and her family members in her teenage years, it was assumed that family were supportive, which was a major factor in stepping down and subsequently closing the case, with little to no exploration of family relationships.
- It is felt that the GP and NEAS input would have been beneficial as they held information that could have informed the ICPC.
- This is a case of a baby suffering the consequences of unsafe sleeping. Work should be undertaken in relation to advice given to vulnerable parents. It appears that Mother did not understand the impact of drug and alcohol use when caring for and co-sleeping with HH.
- There were delays in transferring the case between local authorities and no multi-agency meetings were held after the transfer had taken place. This goes against procedure and a lack of consent from Mother for Early Help services should have prompted an escalation to CSC given the Mother's history and lack of information about the surrounding family.
- It was learned that Mother's partner would have been considered a risk to the child should agencies have known about his presence in the home. It is a possibility that Mother knew he was risky and intentionally concealed his presence. They had only been together 7/10 days prior to HH's death and both had patterns of unhealthy relationships linked to drug use.

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EP Rapid Review

Context

- Three month old EP was found unresponsive at 8.45am by his cousin, who had been staying at EP's family home the previous night. EP was found fully under the duvet that had been covering his cot. He had last been seen fit and well at 1am.
- EP's cousin drew the attention of EP's mother to the cot. Mother commenced CPR and paramedics were called.
- On arrival at the hospital, EP was blue/grey in colour and showed signs that he had passed a lot earlier than he was discovered.
- There was no previous social care involvement with EP or his two elder siblings; however, concerns had been raised by professionals in relation to home conditions, neglect and unsafe sleeping arrangements for all three children.
- On arrival at the family home, there was a strong smell of urine and lots of discarded nappies around the house. There were a number of alcohol bottles in the bathroom and professionals noted that it would be difficult to walk around the room due to clutter.
- EP slept in a cot with a single duvet and a pillow, which Mother stated was necessary to prop up his head due to a previous breathing issue and heart murmur. Mother also stated that EP liked the duvet and being warm and would often pull the duvet over his head.

Background

- EP was the youngest of three siblings to Mother (aged 24) and Father (aged 23). Siblings were aged 3, 1 and 3 months (EP), who all lived in their family home which was a privately rented property.
- The family had a network of extended family members, including maternal aunt and grandparents who live nearby.

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Findings and Learning

- There were no family vulnerabilities identified during assessments and parents engaged well with services during pregnancy and early years for all three children.
- The family home was repeatedly reported to be ‘cluttered’, however no further detail was given. Attention has been drawn to the need for elaboration and clear description when describing the conditions of a home. Upon further exploration, the ‘clutter’ was referring to clothes and toys laying on the floor and surfaces around the home and was not considered to be an unsafe or neglectful environment for the children to live in.
- Parents had been given advice on safe sleeping by health professionals with each birth; however, it was queried whether this was fully understood given the sleeping arrangements that were in place for EP. There were concerns around the description of EP’s cot which had a mobile phone, a bottle of Coke, a colouring book and a large baby play mat in the bottom, below the duvet. Whilst the panel acknowledged that these sleeping arrangements were unsuitable, it was felt to be down to a lack of knowledge and understanding of safe sleeping conditions and poor decision-making, rather than neglect.
- There was a lack of recording around the advice that the family had been given for safe sleeping after EP’s diagnosis of reflux. Mother stated that the hospital had advised that EP be ‘propped up’ when sleeping to manage his reflux. It is important that the detail of advice is clearly reported as this is the second incident since 2021 where a baby has died after being propped up unsafely due to reflux.
- EP’s upstairs sleeping arrangements had not been viewed by professionals and an action has been identified by the 0-19 service around considering a HEAT assessment. It is felt that the unsafe sleeping arrangements would have been addressed had professionals been aware of them.
- It was considered by the panel whether the cost of living crisis had contributed to the decision to cover EP with a duvet. There is a worry that risk-taking around safe sleeping could become more common given the rising costs of heating a home.

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KLT Rapid Review

Context

- On 24/10/23, Mother called a friend to say that she had delivered an stillborn baby in the bathroom of a multiple-occupancy property, who was at approx. 23+5 weeks gestation.
- The day before the birth, Mother reported that her partner (MA) had assaulted her by kicking her in the stomach and giving her a pill which may have been an antibiotic. She is allergic to penicillin. She fell asleep after taking the pill and awoke at approx. 4pm the following day with stomach pains and delivered the stillborn baby shortly after.
- Her partner (MA) cut the cord but otherwise offered no assistance. Other males in the property laughed at Mother and refused to let her leave. No medical assistance was called until Mother made contact with her friend.
- NEAS attended the property and transported Mother to the hospital. MA claims not to be the father of the baby. Mother is a sex working and has diagnosed syphilis. She has had other miscarriages but is not sure how many. She had one child in May 2020 who was adopted in February 2023.
- Mother has reported a previous assault of the same nature several weeks before this incident which prompted a referral to ASC for Mother and CSC for the unborn baby.
- A C and F assessment was started but attempts to contact Mother were unsuccessful as she had no known address and it was unclear whether the number that was used belonged to her.

Background

- Mother reported to be homeless and stated that MA was her partner, although professionals have suspicions that this may be an exploitive relationship.
- Mother remained in hospital after the still birth of KLT and was offered refuge accommodation. She has been allocated an adults social worker and is also open to Harbour.
- MA was arrested and is on bail, but not charges will be brought in respect of KLT due to the gestation.

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Findings and Learning

- It was identified that there were missed opportunities to safeguard KLT's mother and the unborn baby during her pregnancy. Mother's visit to A&E after the first incident of assault in September saw some positive practice in booking pre-natal care whilst there; however, there was a disclosure of a significant episode of domestic abuse and there were no referrals make to adults safeguarding, Harbour or the children's HUB on behalf of unborn.
- There was evidence of good practice from the midwifery team in respect of their creativity in trying to contact Mother via local hostels and charities, even though these attempts were unsuccessful.
- Mother had attended the Emergency Department four times in the last 5 years. Safeguarding referrals were made on two occasions where staff had been made aware that Mother had children; however, on her fourth and most recent visit, there was little curiosity about children or who had been the perpetrator of the assault.
- A missed opportunity to refer UBB to Children's Social Care was identified, when Mother presented as pregnant to her GP surgery. Her history of mental health problems, illicit drug use, sex work and domestic abuse were known, which should have resulted in a referral to CSC. Additionally, Mother was expected to self-refer to the community midwife – given Mother's history of engagement and missed appointments, the likelihood of her doing this could have been explored and a more direct route taken.
- Following Mother's attendance at the Emergency Department in September 2023, it was recognised that there could have been a more thorough criminal investigation into the incident given the significant criminal history of the perpetrator, who had been reported by a previous partner for rape, assault, unlawful imprisonment, drug offences and theft.

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Cross-cutting themes:

- **Assumptions** made across the system without checking them out.
- **Over-reliance** on families or children to report their concerns/struggles.
- **Cumulative risks –** Completion of **holistic assessments** incorporating wider family history and information **(Cumulative vulnerability)**
- **Multiple referrals** – you must always consider all information – referrals/case closure etc.. A chronology will offer a understanding of the long term view and needs all agencies to share this long term info to give a richer picture.
- **Engagement with services and support** – be alert to families saying they will engage with EH/other agencies to avoid CIN and then not engaging. This is a recognised pattern associated with long term neglect.
- **Child's lived experience** – you must always consider the lived experience for the child (critical when there are lots of assessments and no intervention). What is their life like? Has their situation improved since services began their involvement? If not, why not?

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- **Over-optimism** and the progress that a family/parent/plan may have made to the child's lived experience.

- **Vulnerabilities** – reflect on the context for parents to be able provide effective parenting, including an understanding of the support networks. Would parenting be compromised if these networks were not in place?

- **Challenging dis-engagement** - when families do not engage/stop engaging, what is done about this? Does their case need to escalate? What barriers are in the way? How could professionals be creative in getting families to engage?

- **Fathers and hidden males –** it has appeared in several cases that assumptions were made about who was living in the family home or whether father's were involved. Professionals should be curious about who is consistently involved/around the child or children.

- Robustness of **transfer** across all services and sharing of information including across areas.

- **Consent** as a barrier to sustaining engagement when stepping down CP plans.

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