**Shape

Description automatically generated**

**Local Child Safeguarding Practice Review**

Thematic Review

September 2022

**Contents**

1. Introduction page 2
2. Process page 2
3. Learning page 3
4. Recommendations page 15
5. **Introduction**
   1. The East Sussex Safeguarding Children Partnership (ESSCP) agreed to undertake a Child Safeguarding Practice Review (CSPR) by considering two cases where serious incidents occurred[[1]](#footnote-1) following long-term concerns about domestic abuse, alongside other child safeguarding issues.
   2. Family A. Where a young adult stabbed his mother’s partner following a domestic abuse incident between the couple. A younger sibling was at home at the time. The family were known to partner agencies due to concerns about long-term domestic abuse, parental mental health issues, violence, and substance misuse.
   3. Family B. Where the mother’s partner attacked the children’s mother with a hammer. A 13-year-old child, one of two living at home, sustained an injury during the assault and the perpetrator tried to hang himself in the home. The family were known to partner agencies due to long term domestic abuse, parental mental health issues and neglect. An older child who is in care had made allegations of historic sexual abuse from the mother’s partner.
   4. It was agreed that both cases should be considered in this review due to similarities. In both families the adults had significant vulnerabilities, including a history of abuse and neglect in their own childhoods, previous relationships where domestic abuse featured, mental health issues and substance misuse. Both families had older children who were estranged from them or no longer in their care. All the children were the subject of child protection plans. The serious nature of the incidents also resonated with decision makers as they both involved domestic abuse.
   5. Learning has been identified from considering the professional involvement with both families in the following areas:

* Knowing and considering a parent’s history and vulnerabilities
* Working with hard to engage families who refuse to cooperate with child protection planning
* Recognising the lack of an ongoing police response to an issue does not mean that a child is not at risk
* The impact on children of reoccurring domestic abuse and parental mental health issues
* Vulnerable children approaching adulthood
* The impact of COVID-19

1. **The Process**
   1. An independent lead reviewer was commissioned[[2]](#footnote-2) to work alongside local professionals to undertake the review. Information provided to the Rapid Review meetings was considered and additional information was requested from individual agencies via chronologies which included the identification of single agency learning and any improvement actions that were required.
   2. Professionals involved at the time were involved in group discussions about the cases and the wider system. Due tothe on-going response to Covid-19, practitioner participation sessions were held in January 2022 using video technology.
   3. The lead reviewer made many attempts to meet with both families, including Child A1, to identify any learning from their perspective. This was not successful.
2. **Family composition[[3]](#footnote-3)**
   1. The family members will be referred to in the report as follows:

|  |
| --- |
| **Family A** |
| Mother A |
| Mother’s partner to be referred to as Stepfather A |
| Child A1 - although they were aged 18 at the time of the incident, the majority of involvement was while they were a child. They went to a special school and have a history of mental health issues and substance misuse |
| Child A2 – age 12 (all ages are at the time of the serious incident) |
| Child A3 – 4 months old |
| An older sibling who no longer lives at home will also be referred to |
| **Family B** |
| Mother B |
| Mother’s partner to be referred to as Stepfather B |
| Child B1 – age 13 |
| Child B2 – age 11. This child has significant learning difficulties |
| An older sibling who no longer lives at home will also be referred to |

1. **Learning from the review**
   1. When considering the information gained from the Rapid Review meetings, the detailed agency reflective chronologies and discussion with those involved at the time, the learning identified is as follows:

Learning point 1: Systems must enable the impact of a parent’s vulnerabilities and associated risks to be understood by all professionals working with the family, who need to ensure that all available background and current information is accessed and considered when making plans for children.

* 1. Both cases were complex with multiple adult vulnerabilities that presented risks to the children over a considerable period of time. All of the adults had significant histories that were knowable to professionals involved with the children, even though in both cases there was resistance by the adults to engaging with services and a refusal to discuss their childhood and life experiences in any detail. Parents/carers who have had adverse childhood experiences and suffer with vulnerabilities due to their mental health, domestically abusive relationships, and substance[[4]](#footnote-4) or alcohol abuse, are more likely to have children who require a safeguarding response, and those involved with the families were aware that there were likely to be complex parental histories and vulnerabilities that had a significant impact on their children.
  2. Mother A had been in domestically abusive relationships previously, resulting in CSC involvement. Her relationship with Stepfather A was abusive and in 2018 he received a custodial sentence for an assault, with Mother A not supporting the prosecution. She suffers with both mental and physical health concerns and was on medication, including strong painkillers, sleeping tablets and anti-depressants. There was no evidence she was using any non-prescribed drugs during her pregnancy with Child A3 but it is now known that she had been misusing heroin, along with her partner, prior to the serious incident and that the wider family were aware of this issue but did not share it with any professional.
  3. Stepfather A grew up in a family where domestic abuse and alcohol misuse featured. He was well known to uniformed police officers in the area and had an extensive criminal record for violence and drug related offenses, including time in custody. Child A3 was his first child but he had previous relationships where domestic abuse featured. The family home was described as clean and there were no concerns about physical neglect of the children, although financial support was often requested for school uniform and the police were involved when there was a disturbance at the home allegedly due to visitors demanding that debts be repaid.
  4. The condition of Family B’s home was a concern, with the children having been on a child protection plan for neglect in the past, as well as for emotional harm. Mother B has mental health issues, including a diagnosis of bipolar disorder and emotionally unstable personality disorder. She has a history of taking overdoses and voicing suicidal intent as a response to stress, including making numerous statements that the involvement of children’s social care (CSC) was the cause of her poor mental health. She was known to be impacted by the death of a close family member when she was a child and a previous intimate relationship was domestically abusive.
  5. Stepfather B is known to have a history of alcohol and substance misuse. His previous relationships featured violent domestic abuse. Like Stepfather A, he has a criminal record for other violence, including possession of weapons. Those involved in 2021 had some concerns about his cognitive ability, and there was a plan in place to get this assessed. He reportedly attended a special school as a child due to behavioural and learning difficulties and was known to CSC due to concerns about physical abuse at home. He was described during the review as ‘unpredictable’ and ‘violent’. He often intimidated professionals, who also reflected on how this would be experienced by his partner and the children in the home. Mother B denied he was violent or intimidating at home and would not acknowledge that the children were at any risk. She was also adamant that her elder child was lying following their allegations about sexual abuse from Stepfather B[[5]](#footnote-5). This child has been consistently scapegoated by her mother and blamed for the involvement of CSC, which needed to be part of the wider assessment of the potential for emotional harm and neglect of the younger siblings. Stepfather B has children from a previous relationship and there were ongoing concerns about acrimony between Stepfather B and his ex-wife, and the threats and aggression showed to her by both Stepfather and Mother B.
  6. The review has found that not all of those working with the families prior to the incidents were aware of all of the relevant background information. This was due to the families not sharing information, permission not being given to speak to other agencies (such as adult mental health) and the time involved in finding and reading historic agency information. Not fully understanding and considering the adult risks can mean that plans made for children are based on what parents report rather than what is knowable to professionals if they robustly check their own agency records and ask other professionals to do the same and share what is found.
  7. Information provided by parents should always be verified. For example, the extent of Mother A’s health issues and the impact on her care of the children of the medication she was taking needed to be understood or explored with other professionals, including the possibility that she was not as physically unwell as she was reporting. Her scan’s showed no issues, yet she continued to seek pain medication and drugs to help her sleep. This needed considering and clarifying as it could be an indicator of substance misuse. GPs are a helpful source of information about a parent/carer’s health and medication, as well as someone with whom to discuss any concerns about the impact on parenting of certain medications. Information was sought from the GP prior to the birth of Child A3 when a S47 investigation was being completed. This was an opportunity for all the professionals involved in the child protection planning to be aware of the prescribed medication and what it might mean for mother’s parenting of the children. There also needed for consideration of the risk of prescribed drugs being taken into a house where both the Stepfather and Child A1 had known or suspected substance misuse issues. Seeking advice from a substance misuse agency on the impact of prescribed medication if taken alongside illegal substances would also have helped to understand the effect on the user and any related risk to the children.

Learning point 2: Professionals require support when trying to work with resistant and hard to engage families who do not acknowledge professional concerns and refuse to ‘own’ a child protection plan

* 1. There were similarities in both cases about the difficulty professionals had in engaging with the families. Both were largely successful in keeping professionals at arm’s length and they consistently failed to acknowledge professional concerns. The nature of child in need or child protection planning is that it requires the parents to engage in assessments and plans in order to improve the assessed harm and risks to the children. In both cases, the parents largely did not acknowledge professional concerns or contribute to the plans made to improve things. This made it difficult for professionals to work with them and can lead to drift and delay and a feeling of helplessness about how to work with the family beyond monitoring what is happening.
  2. When parents are negative about professionals it makes it difficult for the professionals involved in plans and for the children themselves. There were several examples shared about the children coming across as ‘closed off’, avoidant or directly antagonistic to professionals who sought their voices and tried to understand their lived experiences. In both families it was known that the children had been told that they might be taken into care and that professionals, particularly social workers, could not be trusted. As their older siblings had been taken into care when they spoke about what happened at home, this was a real fear for the younger children. Despite this there were numerous attempts to see the children in both families, balanced with an awareness that this was likely difficult for the children and indeed could increase the risk of emotional harm if the parents reacted badly to these visits.
  3. Child B2 had significant special needs, so it was important to consider their non-verbal communication and monitor how they seemed to determine any deterioration in their presentation, as well as to consider what they might ‘say’ verbally or by their behaviour. His school noted concerns about his unkempt clothing and his anxiety that he may be taken away from home. Social workers had little engagement with him prior to the serious incident. A visit to see him at school would have been a way of ensuring that he was seen, but this raised a dilemma as there was a known risk that he would be removed from school if this was attempted. Because he had good relationships with school staff, they were well placed to provide support to the child and to provide his voice to social workers undertaking assessments.The school themselves worked hard to ensure they assessed Child B2’s voice by using their one to one ‘pupil voice activities’. They raised no concerns.
  4. The voice of the older siblings who no longer lived at home needed to be sought and appropriately considered, as they had firsthand experience of growing up in the families and had ongoing contact. In both cases these children voiced clear concerns about their younger siblings and disclosed ongoing parental substance misuse and domestic abuse. They also made allegations of historic sexual abuse in the case of Family B. It appears that in both cases they had genuine concerns for the younger children and a lot was to be gained from ensuring they were listened to, including considering the response of their mothers to what they were sharing as part of an assessment of their ability to care for the younger children.
  5. While both children in Family A were seen regularly by professionals there was little understanding of their experience of domestic abuse and their views about Stepfather A returning to the family home following his custodial sentence. During the review there was reflection on the difference between talking to children (for example about how they are finding school, whether they have friends, what their interests are and so on, as was evident in this case) and between seeking to understand their lived experience and relationships in the home and their views on the known concerns. In this case their experience of domestic abuse and parental substance misuse and their relationships with their parents and siblings needed to be explored.
  6. Professionals working with both families reported that they could find the parents both dismissive and intimidating. Both families also made complaints about professionals. Family B regularly threatened legal action against the local authority, as did Family A against the midwife who made a referral when the mother was pregnant with Child A3. While the professionals were able to recognise that this was a way of avoiding scrutiny and professional persistence, it remained difficult for those involved who were trying to find a balance between trying to ensure the on-going engagement of parents in order to undertake a robust assessment and to support and protect the children, with the need to challenge the parents and address concerns and risks. When Mother B was told in 2020 that a child protection conference was to be held, she was very aggressive, made threats to kill the social worker and threw things at her. The police had to be called to the social work office where the meeting was held.
  7. Professionals need support and guidance about how to respond when they are unable to work with families due to avoidance and/or threatening behaviour, as well as considering the impact on the children. Those involved in the review felt it would be helpful for their manager to be physically present with social workers and other relevant professionals when they are setting clear boundaries with families about what is and is not acceptable behaviour to secure both the children’s and professionals children’s safety and welfare. Procedures refer to this as a 'Contract of Expectation' or a 'Written Undertaking' and the review agrees that a manager needs to be present when these are drawn up with family members.
  8. Professionals told the review that they are aware of the need to report any violent incidents or threats, and have a process available on their phones to do so. There is a recognised fatigue in regard to this however, and an acceptance that sometimes the job involves having to work with extremely difficult individuals. There are two relevant Pan-Sussex procedures that cover this issue. Firstly, Working with Families who are Uncooperative and or Not Engaging with Professionals[[6]](#footnote-6) and secondly Violence Towards Staff[[7]](#footnote-7). The procedures include the suggestion that a strategy meeting is held in these circumstances to reflect the concerns for the children living in these households and to support the staff who are concerned about them.
  9. The picture was not one of straight refusal to work with professionals from Family A. Improvements were noted in their engagement following a period of custody for Stepfather A in 2018. It appears that they appeared to prefer the approach of certain professionals, and there was evidence that the situation in the home was more settled. The professionals view at the time was that Stepfather A had come off drugs when in prison and that this contributed to the improvements. There were indicators that these improvements were short lived however, with both of the older children (Child A1 and the older child who no longer lives at home) showing behaviour which indicated a response to on-going trauma and the eldest child making allegations of on-going domestic abuse in the home, both adults poor mental health, her mother’s habitual drug use (stating to professionals at the time that her mother had evidence of damage to her nose due to cocaine use), and voicing her fears for her then youngest sibling. When seen, Child A1 stated he wished to leave the family home, but was unable to articulate why, so it was not pursued with him.
  10. The conference chair for Family A had pointed out her concern that the engagement of the parents was superficial and that they had been avoiding professionals, including not attending child protection conferences and often not being home for social work visits. It was also noted that no unannounced visits[[8]](#footnote-8) had been achieved. As both parents denied any further domestic abuse and there were no police notifications, it was agreed that the children would no longer be subject to CP plan. The family had agreed to cooperate with social work visits under a child in need plan that followed. The focus, however, was on providing support as requested by the parents. As the engagement was entirely on their terms, they were seen as cooperative.
  11. It was noted that Family B were particularly hostile to CSC, and to a lesser extent the police. Experienced social workers told the review that the adults intimidating and threatening behaviour was extreme and unusual even in child protection work. They were more willing to work with other professionals, but only regarding the issues the family accepted. It is important in these circumstances that all professionals challenge families who make threats or refuse to work with one agency, particularly when their involvement is crucial, as was the case with CSC. It is understandable that they may be reluctant to do this too forcefully if the family are engaging with them to take the opportunity to positively engage with the children and make a difference. The schools, for example, were concerned that if they pushed too hard, the children may stop attending, particularly when this was permissible due to COVID-19 rules. There were examples of good practice from Child B2’s school in challenging the parents, for example about the physical care of Child B2. They also engaged with the children’s grandmother who would help to reason with their mother when she became agitated and upset, as was often the case. However, it is essential that all professionals involved with a family work together to ensure that a partner agency is not scapegoated and isolated by a family, and that all professionals are clear that this is not acceptable.

Learning point 3: When the concerns or allegations do not meet the threshold for criminal charges , formal multi-agency consideration should be given to why this is and to the potential need to safeguard the child and/or their siblings

* 1. There were concerns across partner agencies about whether Stepfather B posed a risk of sexual abuse to the children who remained in the family home, but an assessment of the risk he posed to these and other children was outstanding at the time of the serious incident, as was an assessment of the mother’s ability to protect in light of her refusal to believe her older child[[9]](#footnote-9). There had been some delays in ensuring that there was a focus on this issue for the younger children as the older child had her own social worker, and the younger children were closed to CSC at the time that the allegations were made. It was agreed that a family assessment should be undertaken but the mother refused to engage with this, stating that in light of a lack of police action and the children not raising any concerns when they were spoken to, it was not required. The case was closed to CSC as it was felt there was not enough evidence to do anything further at this stage. This was despite the allegations made by the older child.
  2. Stepfather B’s alleged physical and financial abuse of his frail elderly mother was also a concern at this time. She was suffering with emerging dementia and the family was living with her. The concerns led to a number of adult safeguarding meetings, which were known about by social workers in children’s services, although this was not sufficiently communicated at the care planning meeting when a request was made for permission to hold a meeting before action, the first stage of legal proceedings. The review was also told that there were serious concerns about the state of Stepfather B’s mother’s property, which were considered when seeing if she could be discharged from a period in hospital. There was less consideration of this also being a home where children were living, despite a record of the home having no working amenities, including toilets. Adult social care was involved in this review, and they have noted learning in relation to the need for their staff to triangulate information and liaise with children’s services.
  3. The police / Crown Prosecution Service (CPS) had not taken criminal action in regard to either the sexual abuse allegations or the allegations of abuse towards Stepfather B’s mother. Historic allegations of sexual abuse from another child in the family had also been made against Stepfather B some years before but the criminal case was not pursued. Those later involved with Family B were not entirely clear why this was. The police and the CPS require a level of evidence that will allow them to prove guilt beyond reasonable doubt. There can still be indicators that a person is a risk and the lack of a prosecution does not mean that there is no risk and that the matter will not meet the threshold for a S47 and/or legal response by the Local Authority. The review established that when this is the case, professionals need to discuss the decisions made with the police and not make assumptions about a decision not to pursue a criminal case against an alleged perpetrator. This could most effectively be undertaken at a review strategy meeting. Another CSPR was undertaken in East Sussex recently where sexual abuse was considered. The review highlighted the need for a further strategy meeting to be held when more or conflicting information emerges.The recommendation made in that review will ensure improvements in this area of safeguarding.
  4. In the case of the alleged abuse from Stepfather B against his mother, her vulnerability means that she was unable to say what had been happening and this made prosecution difficult. In the case of the older child in the family, her level of vulnerability could also have had an impact on the decision of the police and/or the CPS. Both issues pointed to a risk of sexual abuse and violence from Stepfather A to those he was living with that required robust consideration, regardless of the police and/or CPS response. This risk was recognised at the CPF and was to be included in the assessments that were planned.
  5. Not long after the case was closed to CSC the older child in Family B made further allegations about sexual abuse, stating that she felt safe enough in care to disclose more fully. A S47 response followed, with an agreement to hold an ICPC on her siblings. CSC allocated the case to two workers in order to mitigate the risk that was posed to them by threats from the family and to provide support in managing such a difficult case. This was good practice. Those involved recognised that there was little capacity or willingness to change from the mother or her partner, so it was also decided that the case needed to be discussed at the Formulations meeting where appropriate specialist assessments would be requested and at the Care Planning Forum (CPF) for legal advice. Despite this plan, there was a further delay in seeking the legal advice due to a concern that the threshold for legal proceedings was unlikely to be met when there was no new evidence or specific event that would lead to an agreement by the court for assertive action. There is a belief that courts will only agree that significant harm is present (the threshold for a care order) following a serious incident, rather than due to cumulative concerns over time. (See below.)
  6. Family B was discussed at the CPF the following month, but no agreement was given for a legal meeting before action (MBA) at the time. The CPF is chaired by an experienced senior manager and attended by a senior ESCC lawyer. Other professionals from CSC also attend and advice is given to allocated social workers on how to progress a case. The lack of specialist assessments at the time, due to a delay in the SWIFT[[10]](#footnote-10) work, led to an agreement at the CPF to await the outcome of the assessments before considering if a legal response was required. This was accepted and was understandable when considering what was known at the time.
  7. The review was told that there can be a degree of frustration across agencies when a plan is delayed waiting for specialist assessments. Even if it was not considered in this case, professionals need to feel confident in challenging the outcomes from the CPF or know that they can return again to share that they remain worried and why, even without the specialist assessments required being completed. It is acknowledged that this is not easy, as well respected senior managers and lawyers are involved in the CPF and are seen as the ‘experts’ in threshold. In order to ensure that all of the issues are known to the CPF and legal advisors, multi-agency information, evidence of cumulative harm and the evidence that the family have not responded to child protection planning needs to be available in order to convince the CPF of why ‘now’ is the time to progress to a legal response, even when the required assessments have not yet been completed. In this case the MBA may have provided a level of additional persuasion to ensure that the family engaged with the assessments planned, however the review acknowledged that a plan to consider the independent assessments before making this move was understandable, despite the delay it caused. Particularly as both parents agreed to cooperate with the assessments.
  8. With this delay, and limited engagement from the family, the child protection plan in respect of the children in Family B left the professionals working with the family doing little more than monitoring the children and sharing information in the core group. This was a difficult time for the family and for the professionals involved. The parents had voiced their concern about the assessments due to be completed and the delay exacerbated their anxiety and impacted on the increasingly negative relationship with the professionals involved in the child protection planning. While there had been no progress in the face to face assessments, there had been consideration of agency records by SWIFT staff, who were concerned about managing the assessments while also keeping the children and their mother safe. They wanted to undertake the cognitive assessment meeting with Stepfather B at the same time as the assessment meeting with the mother, so as to ensure that Stepfather B was not present with his partner. The review was told that it was the cognitive assessment that delayed things, with both psychology staffing and capacity issues at SWIFT delaying this. A date had been set for the assessment meeting, which was just after the serious incident. The review was told that while resource and capacity issues were present at the time and had an impact on this case and others, there is now increased capacity at SWIFT and far fewer delays in assessments when children are on a child protection plan.

Learning point 4: Professionals need to understand the ongoing and reoccurring nature of domestic abuse and parental mental health issues to fully appreciate the impact on children

* 1. There had been both historic and more recent domestic abuse in the majority of the adult relationships of both sets of parents. Both stepfathers witnessed domestic abuse during their childhood. This is known to have an impact on their own expectations of relationships, and research shows that children who have experienced parental domestic violence are ‘at greater risk of being victims or perpetrators as adults’ due to the intergenerational cycle of this type of harm.’[[11]](#footnote-11) It is also known that a long-term illness or disability, including mental health problems, increases the risk of being in a relationship that is domestically abusive.[[12]](#footnote-12) This was the case for all four parents.
  2. It is essential that professionals consider the evidence of domestic abuse in the relationship in the past, at the time and also the likelihood of domestic abuse reoccurring. Particularly where there has been limited insight from the adults involved into the issue and little or no work undertaken to confront and address the problem. The Triennial Analysis of SCRs undertaken between 2011-2014 identified that a change is required in how we understand and respond to domestic abuse, ‘there is a need to move away from incident-based models of intervention to a deeper understanding of the ongoing nature and impact of domestic abuse.’ This is relevant to these cases, as there is evidence that professionals were reassured, and decisions were made in light of the lack police reports.
  3. In both of cases there were no reported new incidents of domestic abuse in the months prior to the serious incidents in 2021. In Family A there was a presented picture from the family that after the stepfather’s release from prison in 2018 there had been no further domestic abuse, substance misuse or need for concern about the parent’s mental health. There had been no police involvement for some time, and social visits to the family as part of the child protection plans did not lead to any concerns being identified. Mother’s older child, who did not live at home, was very clear with professionals however that these risks were on-going. A child protection conference in October 2019 agreed that the children should no longer be subject to a child protection plan due to a lack of evidence that the concerns which had led to a plan remained. This was despite the child protection plan largely not being achieved, including no evidence of the required random drug testing, no psychological assessment of Stepfather A, no domestic abuse work and the evidence of on-going serious concerns about Child A1, who required on-going support and transition to adult services. (He was age 16 at the time.)
  4. Shortly afterward the child in need plan was closed it became clear that Mother A was pregnant. Research shows that both pregnancy and the presence of a newborn baby increase the risk of domestic abuse significantly. The pre-birth period is a good time for reflection and reconsideration for professionals involved in a family where there have been long term concerns about domestic abuse, mental health, and substance misuse. The information available from CAMHS regarding the impact of his experiences on Child A1 provided evidence of long-term abuse and trauma to the children in the home, and it was known that no work had been undertaken by the parents to address the concerns. In fact, the family were clear when they were visited by social workers that they would not cooperate with an assessment regarding the new baby or the older children, and after undertaking agency checks it was agreed that the threshold for child protection response was not required. This was despite three contacts in recent months from different wider family members that the couple were misusing drugs (specifically crack cocaine and heroin), how vulnerable babies are, and the impact on the older children of a growing family. There was a discussion between the police and CSC to decide if a strategy meeting was required, but the police visited the family, had no concerns so it was agreed that no further action was required. Health agencies were not consulted. The assessment that was then completed was not a pre-birth assessment, did not take into consideration the parents not disclosing to midwifery that they had recent CSC involvement or their lack of cooperation with the assessment, and there was no evidence that the long history of concerns was considered or that the voice of the unborn baby or the impact of their experiences on the older children was considered.
  5. The case was reopened for assessment two months later when the midwife made a referral to CSC to state that Mother A was not engaging with routine midwifery appointments or following medical advice. A strategy meeting[[13]](#footnote-13) considered this information and received updates on the older children and identified concerns about declining school attendance for Child A2 and police intelligence regarding the stepfather’s heroin use and dealing. It is good practice that police intelligence is considered but there is a limit to how it can be shared with families. This information however should have been considered alongside both the historic substance misuse and the information shared a few months earlier by family members. Without ongoing support from substance misuse services this was a risk that was likely to reoccur, along with domestic abuse and fluctuating parental mental health, both of which were likely to be exacerbated by substance misuse. Despite this the case was closed prior to Child A3’s birth. The allocation of a new social worker when the family was referred by the health visitor when Child A3 was three months old and good information sharing and awareness of risks in the family from the health visitor led to a full consideration of the history and a decision to hold an initial child protection conference. The serious incident happened before this could be arranged.
  6. In respect of Family B it has been identified that professionals in adult services engaging with parents due to their own issues, require support and oversight to ensure that they are aware of the need to always consider the impact of the issues on any children living with the adults concerned. This includes the requirement to share information, even without consent, when the children are either subject to a S47 investigation or on a child protection plan. The impact of GDPR[[14]](#footnote-14) and the perceived limitations to information sharing requires ongoing and further clarification and support to ensure that information sharing is not a barrier to safeguarding children.
  7. A few days before the serious incident, Stepfather 2 was taken to hospital by ambulance following a mental health episode and overdose at home. During this incident he apparently threatened his partner and appeared to be hallucinating, saying unknown people were in his home. This incident has identified several systemic issues, particularly regarding information sharing that had an impact on the response to this incident. Those working with the children were not aware of the incident. This is because it happened on the weekend and information sharing ‘out of hours’ is not as effective as during office hours. The review was told that there was significant pressure on services over the weekend in question. There were gaps in the information sharing from the police to the ambulance service and then from the ambulance service to the hospital. The mental health assessment then undertaken on the ward considered the overdose but not the detail of the incident, including the serious threats made to Mother B. The stepfather told the mental health professionals that he had no contact with his own children, which was the case, and at the hospital he attended there were no flags/alerts on his notes to show that he lived in a household where children were on a child protection plan. The Acute Trust have identified learning about the importance of thinking family when there is a presentation of this type and of records needing to reflect a patient’s living arrangements. There only reference on his mental health service notes to any contact with CSC about his partner’s children were strategy meeting minutes uploaded into correspondence, so not easily accessible to busy hospital staff. The mental health trust is completing a parallel serious incident review of what occurred during this episode in relation to use of the Mental Health Act and this will be shared with the ESSCP when it is finalised[[15]](#footnote-15).

Learning point 5: There is cumulative risk of harm to a child when parental and environmental risk  
factors are present in combination or over periods of time. This need to be considered when plans are made, including when there may be a need for legal action

* 1. The national Safeguarding Practice Review Panel’s second Annual Report published in May 2021[[16]](#footnote-16) states that ‘the recognition of cumulative[[17]](#footnote-17) neglect and its impact continues to be a key challenge for practitioners’ nationally. There is a danger when working with cases of long term neglect and /or emotional harm that agencies wait for a serious one-off incident to happen to provide evidence to each other or to the courts that the children are suffering significant harm on a given day. With neglect and emotional harm, a number of smaller issues or concerns when collated may show significant harm over time. There is a cumulative impact on children of care that dips just above and then below ‘good enough’ on a regular basis. Both of these cases are good examples of this. Assumptions can be made about the resilience of children in cases where the concerns are chronic and long term. For example, Child A2 was fiercely loyal to her mother and step father and seemed to be managing her home life well. However it is known that experiencing long term emotional harm often manifests when a child reaches adolescence, and it is often then that their behaviour begins to decline and professionals become concerned. Those now working with Child A2 in secondary school have concerns about the impact of her experiences.
  2. In the case of Family B, there was a plan following discussion at a Formulations meeting to undertake specialist assessments, including a cognitive assessment of step-father B[[18]](#footnote-18), an assessment of his sexual risk, and a psychological assessment of the mother, including her ability to protect the children. The face to face assessments had not started when the serious incident happened six months later. The social work team were concerned and felt that a meeting before action[[19]](#footnote-19) (MBA) was required, but the Care Planning Forum did not support this at this stage, despite recognising the risks. This has raised questions about the information shared and whether an argument for cumulative concern was shared and the confidence of senior managers and legal services that the court would consider this. The review has found that there was a rigorous consideration of much of what was known and that there was a view that following the assessment that were planned, care proceedings may be suitable.
  3. In both families there were a number of different issues which posed a risk to the children, and the long term nature of these concerns added to the likelihood of harm and repercussions for the children. If risks are to be judged on a single day, they may not meet the threshold for statutory intervention, be that S47, CP planning or the PLO/care proceedings. But viewed over time, the impact of their experiences is magnified and the likelihood of significant harm increases. This was clearly the case with Child A1, and the older children in both families who were no longer living at home and were struggling with their own significant vulnerabilities. The likelihood that their experiences were going to be repeated with their younger siblings needed serious consideration.
  4. As posed by the chronology author for CSC in respect of Family B, the review also asked how social workers can gain confidence in using historical patterns as evidence. The same question is relevant to all professionals. It is essential that patterns over time are considered when any professional is considering the threshold for a referral or an escalation of a professional disagreement when there are concerns that children are not being safeguarded. This, along with a clear understanding of the child’s lived experience and the family culture and the likelihood that concerns will reoccur over time without significant interventions and evidence of sustained change, is the answer to this question. When there is a clear case of reoccurring risks, the likelihood of ongoing harm to the children needs to be the focus of action taken, rather than professionals feeling helpless due to what they see as the burden of needing to prove that harm is present at a given point on a given day.
  5. The review found evidence of resolve and persistence of professionals in supporting children in both cases despite the parent’s hostility. The social worker involved with Family B at the time of the serious incident knew the children well and was clear that they were likely to suffer significant harm. She felt however that she required the evidence that a specialist assessment would give in order take action. In both cases there was evidence of communication between the conference chairs and those working the cases between conference, which was a reflection on the complexity of the work and a commitment to safeguarding the children.
  6. Those involved understood the importance of a child centred approach, and the need to seek information on the lived experience of the children. This is complex process work however, and needs to take into consideration that children are often conflicted or scared to engage with professionals due to their fears of what might happen next or the response of their parent/s if they say the wrong thing. There is evidence of reflection about this in both cases, and some understanding that behaviour is a means of communication and what they might be saying without words.[[20]](#footnote-20) However the explicit concerns shared by the older children needed to be heeded with a clear focus on what this meant for the younger children, despite the parents attempts to discredit them.

Learning Point 6: As children approach adulthood, those who are known to be vulnerable, particularly those that are on a child protection or child in need plan, require on-going and focused multi-agency support with a clear plan to ensure that they are not ‘lost’ to the system

* 1. Child A1 was a child for most of the time that the review considered in detail. It was his 18th birthday not long before the serious incident that led to this review. Much of the work undertaken with the family considered the risk to the younger children of Child 1A’s behaviour. Child A1 had ADHD with some obsessive behaviours and a difficulty in controlling his behaviour. He had been prescribed a number of drugs for his mental health throughout his later childhood. They included anti-psychotic medication, although the assessment undertaken by FCAMHS concluded that rather than having a psychoticillness A1’s presentation was more suggestive of extreme anxiety and learned relational/attachment behaviours, within the context of complex developmental trauma. There was a plan in place to reduce his prescribed medication, which he resisted. Those who knew him well believed he strongly identified with his mental health diagnosis and was reluctant to reconsider if it was valid.
  2. Professionals were aware that there was a risk to him having large amounts of this medication available to him at any time, so they arranged for his prescriptions to be collected weekly. He was known to misuse drugs, as he did not hide this. Professionals were aware that he had gym equipment and used it very regularly, but not all were aware of his abuse of illegally sourced steroids. This was significant information as it is known that misusing steroids can have a negative impact on anger control, with people reportedly acting aggressively when misusing them regularly[[21]](#footnote-21). He was referred to substance misuse services but did not engage.
  3. Child A1 had an EHCP and was known to CAMHS, EIP (Early Intervention in Psychosis) and FCAMHS (Forensic Child and Adolescent Mental Health Services). His engagement with mental health services while a child was sporadic, with his school taking much of the responsibility of ensuring he was seen when required. When he left school at age 16 his engagement with most mental health services declined. For the children in both families, school was a safe place where they received support. When this was no longer in place for Child A1, both his mental health and his ability to manage was impacted.
  4. Child A1 was on a child protection plan until he was 17 years old, and he was then on a child in need plan until he was 18 years old. The last RCPC before his 18th birthday noted that he was not in education employment or training (NEET), despite his Education Health and Care Plan (EHCP). It was recorded that he had no plans to go to college and that he was not wishing to engage with mental health services as he blamed CAMHS for changing his medication against his wishes. The child protection plan ended without a clear steer that the child in need plan that followed needed a formalised network of support specifically for Child A1 in respect of his future. There was no progress in this area for him prior to his 18th birthday and he had no key worker taking responsibility for him.
  5. When a child/young person has an EHCP this can be in place until the age of 25 providing that they are engaged in appropriate education or training that provides a forward pathway.  The EHCP is important in providing an oversight of needs and provision required, and has the potential to provide access and funding to support the engagement of the young person. In this instance the EHCP was ceased owing to a lack of engagement from the family, meaning he became an adult without a plan for his transition, despite his known vulnerabilities. The review was told that a plan is being devised to focus on this issue, and this case should be used an example of what is required to ensure that the hardest to reach young people are helped.
  6. There were attempts to consider how he could receive support in his own right after leaving school, which was complicated by his lack of engagement with services much of the time. For example, when he was closed to CAMHS, Primary Care was asked to follow him up in regard to his remaining prescriptions. While this would meet the purpose, he was a very vulnerable young man who was likely to require support as he transitioned to adulthood, and support from his parents to do so. Those who knew him well told the review he required ‘holding’ as he approached 18 to ensure that he was not lost to services, and would have benefitted from a relationship with a key worker whose job it was to remain in contact with him and provide the advice and support that he was likely to require. At the time of his 18th birthday, adult mental health services were able to offer assessment and treatment with COVID 19 protocols in place for those open to their service. Child 1A was not open to them however but knew that he could access the Sussex Mental Health Line[[22]](#footnote-22).
  7. Child A1’s previous school have identified a gap in service delivery as a systems issue for a lot of post 16 young people, with only those with serious disabilities or who are in care receiving effective support into adulthood. A national issue was also raised for young people like A1, because he received benefit payments due to his disability/vulnerability, this was a disincentive for him to consider his future. There may also have been a concern for Child A1 about his mother and younger siblings that made him want to stay home to care for them. This was not considered at the time.

Learning point 7: COVID-19 had an impact on the families and the professional response

* 1. The NSPCC has highlighted the heightened risks to children during the COVID-19 pandemic due to the increase in social isolation, lack of access to some services, the ability for professionals to pick up on early warning signs, and financial insecurity[[23]](#footnote-23). There has reportedly been a negative impact on mental health, domestic abuse[[24]](#footnote-24), and potentially on substance and alcohol misuse. Both incidents happened during the pandemic and it is right that the review considered the impact.
  2. In both cases Covid-19 was a challenging time for the families and for the professionals working with them. Research shows that social workers were often the only professionals going into family homes during the initial lockdown[[25]](#footnote-25), and this often took a lot of negotiation for families to allow this. As the Family B reflective chronology author for CSC stated, for some families COVID-19 was ‘a gift’, and this was indeed the case for both of the families being considered, with the parent’s history of reluctance to engage with professionals.
  3. Professionals have reported generally that visiting families while wearing PPE and trying to practice social distancing, at a time when there was a genuine fear about contracting COVID-19, was very difficult. When colleagues needed to shield due to health conditions, this also had an impact on the capacity of those able to work face to face to see families as often as required. While necessary in some cases, attempting to ‘see’ families via video technology was difficult and potentially provided false reassurance, particularly with families like these who had a history of avoidance of professionals. Despite this there was good evidence of effective and focused work from all agencies in East Sussex during the pandemic and challenge of families who tried to avoid scrutiny. In both cases there were a number of examples of admirable tenacity and care shown to the children by the professionals involved.

**5 Conclusion and recommendations**

5.1 There has been excellent cooperation with this review from partner agencies, which was essential in establishing the thematic learning. Single agency learning from both cases was identified during the review and recommendations have been agreed to address these, including single agency SMART action plans. For example Child A1’s school plans to negotiate the provision of a specialist post-16 service for pupils with SEMH needs[[26]](#footnote-26) who are unable to attend a post 16 mainstream setting for children like Child A1.

5.2 Having considered the learning not addressed in the single agency actions, the following additional recommendations are made:

**Recommendation 1:**

That the Partnership requests information and assurance from the relevant agencies regarding the identified need for improvements in processes and practice to support the transition of vulnerable school leavers, including those with an EHCP.

**Recommendation 2:**

That the partnership asks ESCC Children’s Social Care and Legal Services to consider how they can ensure that:

* A multi-agency view of the need for a Meeting Before Action is sought and considered at the Care Planning Forum
* Historic information across agencies, including patterns and cumulative concerns are available and considered at the Care Planning Forum
* Social workers and core groups are supported and encouraged to challenge Care Planning Forum decisions if they don’t agree with them

**Recommendation 3:**

The Partnership to seek assurance from all relevant agencies that professionals are supported when working with threatening and abusive behaviour from family members. The partnership must also ensure that professionals consider the impact on the children of such behaviour, including promoting the use of the existing procedures that suggest a strategy meeting is held following a serious threat to a professional or if a professional is assaulted.

**Recommendation 4:**

The Partnership to seek assurance that the learning from this review is considered by all agencies and that the following areas of learning are routinely reflected in practice:

* The serious impact of the cumulative and reoccurring nature of neglect and emotional harm
* The need to ensure that information is sought and shared regarding parental/adult and family history that is likely to pose a risk to children

**Recommendation 5:**

That SPFT share the findings of their serious incident review of the application of the Mental Health Act during Stepfather B’s admission just prior to the serious incident, including any improvement actions that are being taken.

**Recommendation 6:**

The Partnership to challenge the relevant partner agencies about how professionals who work with adults/parents can be better involved in working with families where there are concerns about the children.

**Author:**

**Nicki Pettitt**

1. Both incidents occurred in 2021. The delay in completing the CSPR was due to the limited capacity of partner agencies due to other reviews and the on-going impact of COVID19. At the time of publication there are no on-going parallel proceedings. [↑](#footnote-ref-1)
2. Nicki Pettitt is an independent social work manager and safeguarding consultant. She is an experienced lead reviewer and is entirely independent of the ESSCP. [↑](#footnote-ref-2)
3. Both families are white British and no specific learning regarding the professional response to their culture was identified during the review. [↑](#footnote-ref-3)
4. The term ‘substance misuse’ in this report is used to refer to illicit drugs, unless prescribed medication is specifically stated. [↑](#footnote-ref-4)
5. Another family member had made allegations of child sexual abuse against Stepfather B around five years previously. [↑](#footnote-ref-5)
6. <https://sussexchildprotection.procedures.org.uk/tkyqyq/children-in-specific-circumstances/working-with-families-who-are-uncooperative-and-or-not-engaging-with-professionals/> [↑](#footnote-ref-6)
7. <https://sussexchildprotection.procedures.org.uk/tkyqys/children-in-specific-circumstances/violence-towards-staff> [↑](#footnote-ref-7)
8. When children are on a plan there is an expectation that some social work visits are unannounced. [↑](#footnote-ref-8)
9. It is noted that despite the failure of her mother to believe her and the family scapegoating her and blaming her for the involvement of CSC with her siblings, the older child from Family B remained in care under S20. This has been raised with CSC as the review found that there was a clear need and grounds for care proceedings in her case. [↑](#footnote-ref-9)
10. A local jointly commissioned, multi disciplinary provider of specialist assessment and intervention. [↑](#footnote-ref-10)
11. # NSPCC Research Review: Early Childhood and the ‘Intergenerational Cycle of Domestic Violence’ (2019).

    [↑](#footnote-ref-11)
12. Recognising and responding to domestic violence and abuse. Quick Guide. SCiE 2020 [↑](#footnote-ref-12)
13. Single agency learning was identified about a member of staff from the midwifery service informing the parents about this strategy meeting, in contravention of procedures. [↑](#footnote-ref-13)
14. General Data Protection Regulation - Data Protection Act 2018 [↑](#footnote-ref-14)
15. The CSPR was told that the timescales for completion mean that the CSPR would be signed off and potentially published before this parallel review was completed. A recommendation has been added to ensure that the findings and actions from the review are shared with the ESSCP. [↑](#footnote-ref-15)
16. <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/984767/The_Child_Safeguarding_Annual_Report_2020.pdf> [↑](#footnote-ref-16)
17. The terms ‘cumulative risk’ and ‘cumulative harm’ were first identified by Bromfield and Higgins in Australia in 2005 who defined cumulative harm as ‘the effects of patterns of circumstances and events in a child’s life which diminish their sense of safety, stability and wellbeing. Cumulative harm is the existence of compounded experiences of multiple episodes of abuse or layers of neglect.’ [↑](#footnote-ref-17)
18. The review was told that Stepfather B said he had acquired a brain injury when young. SWIFT were going to consider this in his cognitive plus assessment as part of his functioning and because it may have impact on how he is worked with. His mental health records show that he has had a number of head CTs and MRI prior to the incident however and none indicated a brain injury. [↑](#footnote-ref-18)
19. This is the local process for starting a Public Law Outcome (PLO) response, with the agreement of the CPF. [↑](#footnote-ref-19)
20. The voice of the child: learning lessons from serious case reviews. Ofsted 2010 [↑](#footnote-ref-20)
21. https://www.drugabuse.gov/publications/drugfacts/anabolic-steroids [↑](#footnote-ref-21)
22. He did contact this helpline on one occasion around 10 days prior to the incident. [↑](#footnote-ref-22)
23. Both parents in this case were said to be stressed about their financial predicament and housing situation. [↑](#footnote-ref-23)
24. The Office for National Statistics states that the number of arrests for domestic abuse-related crimes between 1 April and 30 June 2020 increased by 14% compared with the same period in the previous year. [↑](#footnote-ref-24)
25. Harry Ferguson, University *of* Birmingham. Professional Social Work magazine 6.12.21 [↑](#footnote-ref-25)
26. Social Emotional Mental Health needs [↑](#footnote-ref-26)