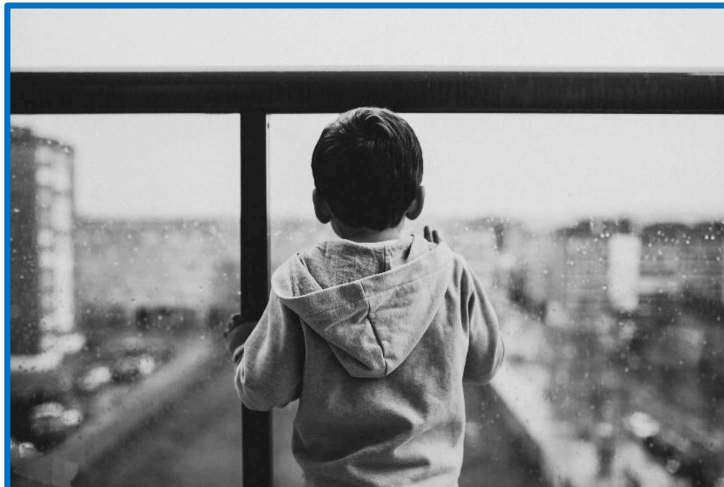
Local Child Safeguarding Practice Review Executive Summary

Child J



Report Independent Author & Lead Reviewer: Suzy Kitching, MBE

Date Agreed by DSP: 11 November 2024

Introduction to the review

This Local Child Safeguarding Practice review was commissioned by Darlington Safeguarding Partnership to consider the systems and practice and multi-agency responses, following the death of a child under two years of age who died from a head trauma consistent with a non-accidental injury. To support anonymisation, he will be known as Child J. The review explored the importance of knowing parental mental health history and the impact that had on the wider family, the children's lived experiences and the role of unseen/unconsidered adults and caregivers.

Working Together to Safeguard Children 2023 statutory guidance sets out the process for Local Child Safeguarding Practice Reviews. The Partnership appointed an independent author (Suzy Kitching, MBE) to lead the review.

Story of the child and family

Child J and his parents were White British. He lived with his mother and elder half-sibling and at the time of the significant incident, mother's partner was at the family home. She had been in a relationship with him for a period of 10 months before the incident. He had his own home, however, is understood he spent periods of time in the family home.

The family were involved with universal and voluntary services at the time of the significant incident. There had been previous statutory involvement with all of mother's children. Child J was born prematurely and was vulnerable due to his mother's long standing mental health difficulties, her reported childhood trauma, her relationships with at least two males where domestic abuse featured and neglect of her elder children. Child J was not brought (WNB) for a number of health appointments. Mother continued to experience periods of difficulties with her mental health as well as periods of stability. She has been proactive in accessing support and help from a range of services and professionals which was positive. The family received support from a number of different agencies, including voluntary sector providers over the past five years. Whilst mother's history is significant to the review, it was not explored in great detail, however, will support future learning regarding neglect and harm.

Parallel criminal investigations regarding Child J and Care Proceedings for sibling were ongoing during the period of the review and at the time of writing mother's partner was on remand, charged with murder and mother on bail, charged with child neglect. At the time of publication, mother's partner had been sentenced to life imprisonment (minimum of 25 years) and mother sentenced to four years imprisonment.

Summary of key learning themes

The review reflected on four key themes that helped the Partnership understand what had happened and what this meant for the children in the family and what it meant for practice.

The Children's lived experience and what it was like to be an infant and child in this family

Understanding what life was like for Child J and his sibling was an important element of this review. To assess and appreciate the circumstances and individual strengths and vulnerabilities of children, practitioners need to identify why their needs may not always be met and consider why parents/carers may behave as they do. This means also understanding the lived experiences of parents/carers and thinking about what they may need to help their children thrive along with an understanding of other factors which may be affecting family life, such as new relationships, mothers' mental health difficulties, domestic abuse and financial issues.

Being curious and exploring parental history is critical to understanding parental capacity, risk and safety. Services did understand that the family needed help, and practical support was provided to help build resilience for child J's sibling, however there was often too much focus on the adult's problems and was never seen as an indicator of neglect. Practitioners need to observe interactions between children and their parents/carers and through direct work to help understand that children communicate through their behaviour and physical presentation.

Parental Mental Health impact on parenting and family functioning

The review evidenced some good strength-based approaches to support mother's mental health difficulties from those services involved, however the focus was all too often on her needs with limited understanding of the child's experiences. Not all practitioners involved with the family had full knowledge of her long-standing mental health history or what her mental health difficulties meant. She was often open about her difficulties and mental health diagnosis and proactively sought help when she felt her mood dipping. There was limited reflection and curiosity about mother's family functioning and whilst there was a range of adult service responses and assessments to her mental health needs, they were not widely shared or used to inform family assessments. Child J's siblings' anxiety and behaviours were directly linked to what was happening at home, mothers fluctuating moods and who was providing care.

There was evidence of neglectful home conditions and whilst practical support was provided the underlying reasons were not fully appreciated or assessed, meaning improvements were short-term. Mother's mental health crises were often dealt with episodically with no reflective and holistic multidisciplinary assessment of her mental health needs and the impact on the children. Practitioners need to strengthen their knowledge and understanding of the impact of parental mental health difficulties on the care of children and family functioning and practice 'whole-family' working where parental adult issues impact the wellbeing of children.

Unseen or unconsidered adults and caregivers within the household and their role with regard the children

The review explored the men and caregivers involved with the family and what was known about them and their role with the children, they were not unseen but unconsidered. There were males involved with the children's lives and referenced as supporting and caring for the children at various times but limited professional curiosity to explore more about them.

There was limited knowledge of mother's current partner and whilst police checks were made, there was no indication that he presented any risks to the children and further exploration of his role in the family was missing. The mother's report that her partner did not stay overnight was not challenged and accepted at face value. There should have been greater curiosity about him and some exploration of his role in the household, knowing who is involved in a household is important when providing help and support to families and considering risks, vulnerabilities, and support they could provide. There was often an over reliance on mothers' narrative and practitioners should be curious about all household members or those involved in the care of children.

Multi-Agency Working providing help, support and protection

It was evident that professionals worked hard to engage with the family and provided a wide range of support and help and positive relationships were developed. The range of services was extensive from across child and adult services, including specific voluntary services who mother chose to support her. There appeared to be over confidence that the range of services meant the family's situation was fully supported, however the support was intermittent and there was a lack of clarity about who was doing what, when and with whom. There was significant involvement from voluntary agencies which provided a high level of practical and emotional support, however no sense they formed part of a multi-agency community support network. Many services did not know the full background and often relied on mother's narratives. Mother sometimes failed to take child J to health appointments, these were not patterned or viewed in context of Was Not Brought policy (WNB) and wider neglect factors for both children. Mother often sought support and failed to engage, and disguised compliance was not considered as a factor.

There was evidence of multi-agency meetings and services, however this was limited or only involved one or two agencies, meaning information was seen in isolation. All parts of the family and multi-agency system must be actively engaged in triangulating information to support analysis and ensure help and support can fully meet the children's individual needs within the family. There were opportunities to reflect and analyse the family's history, circumstances, needs, worries and protective factors which were missed and a coordinated multi-agency interdisciplinary response that attended to both the adult and children's needs could have benefitted the family.

Key Learning Points

- Understand the significance of vulnerability, harm, adversity, and trauma by exploring and understanding parental history
- Appreciate what it is like to be an infant and/or child in the family. Ensure all family work focuses on the infant/child's lived experience
- Ensure managers and practitioners regularly reflect on and sense-check the information they have, seek, and share through curiosity and multi-agency critical thinking

- All adults/carers associated with the household should be involved in assessment and planning so support, protective factors, vulnerabilities, and risks can be clearly understood from the child's perspective
- Strengthen knowledge and skills in recognising and understanding neglect and its impact on child development and wellbeing
- Improve understanding of long-term parental mental health difficulties and their effects on parenting and family functioning across adult and child-facing services
- Establish whole family working that ensures shared responsibility where there are parental mental health difficulties. This means taking a whole-family approach to risk assessment and support, particularly at critical times such as pregnancy
- Multi-agency assessment and planning meetings must bring together the family, community network and the agencies involved (including voluntary sector agencies) for the whole family to seek and share information
- Enquires should always include an assessment of all adults living and associated with the household and their roles and relationships with the family
- Improve curiosity about all household members and the role of fathers and male caregivers in their interactions with children

Conclusion

This review has identified important learning for the partnership to consider and reflect upon regarding current systems and practice. Child J was an infant with increased vulnerability due to his premature birth, his mother's long-standing mental health difficulties and adversity, and unexplored male associations with the household. The learning review has reflected on the broader family circumstances and the vulnerabilities and needs of the children and how services worked together to support the family and help the children thrive.

Practitioners and services worked hard to engage and support the family over time, and a particular strength was some enduring relationships for Sibling D and her mother. However, there are important improvements that will need to be considered to support change that can make a difference in practice; these include being curious, reflective, and having a questioning mind about family history, current family functioning, and relationships, appreciating the impact of adult vulnerabilities upon infants/ children in the household, including domestic abuse. It is important that the range of multi-agency colleagues across adult and children's services working with the family at different times, including the voluntary sector, take a whole-family approach that focuses on the children's needs in the context of their experiences.

A number of recommendations were identified to reflect the areas deemed as priority areas for improvement and are outlined below. At the time of publishing the report, the

Partnership has yet to determine the specific actions needed to address the recommendations which will lead to the improvement of practice and systems.

Recommendations for the Partnership:

Practice

1. Darlington Safeguarding Partnership to evaluate the impact of the learning transfer from recent work undertaken regarding Family H which mirrors key learning from this LCSPR. This can strengthen and provide assurance concerning knowledge, skills, and confidence in the following areas of practice:
    a. Understanding children's lived experiences and appreciating what life is like for infants and children.
    b. The use of critical thinking to fully consider a family's circumstances and understand the child's lived experience, known as 'professional curiosity.'
    c. Ensuring all men associated with the family /adult caregivers are fully considered.
    d. Effective information sharing and seeking about the adults and children in the family during multi-agency discussions/meetings.
2. Darlington Safeguarding Partnership to strengthen knowledge and understanding of the following practice areas across the multi-agency workforce, including the Voluntary Sector.
    a) Increased understanding of adverse childhood experiences and how they can impact and what can help.
    b) Increased understanding of parental mental health difficulties on parenting, family functioning and impact upon infants /children.
3. Darlington Safeguarding Partnership to update its multi-agency practice guidance about neglect and provide a good level of knowledge and expertise to support the identification of neglect and pathways of support and intervention. This should be informed by how its identified Practice Tools can help practice and improve outcomes for children.

Systems

4. Darlington Safeguarding Partnership to have clear systems in place to support collaboration across adult support services (including but not limited to community and hospital services, GP's commissioned services) and children's services where there are parental mental health difficulties to support information sharing and assessment. This assessment must focus on the infant/child's needs, vulnerabilities, protective factors, and risks to inform parental capacity and understand the lived experience of the children.
5. The Partnership's Neglect Strategy to reflect on the research and understanding about adverse childhood experiences and building resilience for families through

multi-component programmes, family-based interventions, trauma-informed approaches, and prevention strategies to support wider system change and build resilience and repair for children.

6. The Statutory Partners to provide leadership and guidance about developing a child-centred approach within a whole family focus, in line with the multi-agency expectations in Working Together 2023 that supports the needs of all family members and considers how they interact.
7. Partners should ensure that all adults associated with the family and their roles are identified and considered within their services. This reflects national learning and local briefings about ‘unseen’ male and female roles within the family.
8. The learning from this LCSPR is disseminated across the Partnership and partner agencies to provide evidence to the partnership of how the learning is making a difference in practice to children and families they work with, particularly at a universal and early help level (all learning points).

Two additional recommendations were identified following a meeting with Child J’s family following conclusion of the criminal trial which will help strengthen the learning of the involvement of separated fathers.

9. Darlington Safeguarding Partnership should consider how any written correspondence is followed up to help support family understanding of the review process as well as importantly, providing reassurance.
10. Darlington Safeguarding Partnership to consider how it promotes information to communities about safeguarding being everyone's responsibility, recognising that for some separated families, contact may be used to control access to children. Information, advice, and guidance should be accessible to extended family members who have worries about children’s wellbeing.