# Norfolk Safeguarding Children Partnership Child Safeguarding Practice Review

# Child AK

# January 2023

## Introduction

Norfolk Safeguarding Children Partnership were notified of the sad death of Child AK. At the point of referral, it was suspected that Child AK died as a result of overlay[1] whilst in her mother's care; mother was allegedly under the influence of drugs and alcohol at the time. The Rapid Review[2] that took place following Child AK's death concluded that the criteria for a Child Safeguarding Practice Review (CSPR) had been met and that a deeper analysis was likely to highlight important learning for the local area. Norfolk Safeguarding Children's Partnership (NSCP) agreed that a CSPR should commence. At the latter stages of this CSPR, the inquest took place. The coroner recorded an 'Open Conclusion'[3] as to the cause of death.

## Methodology

This CSPR has complied with relevant guidance[4]; relevant information has been supplied by agencies involved in providing services to Child AK and her family; a panel of agency representatives, who had no direct involvement in the services provided, has met on several occasions; the perspectives of practitioners has been gained, and family members have given their views. An independent lead reviewer has authored this report.[5]

## Scope

The scope of this CSPR covers a period of one year which includes mother's pregnancy until Child AK's sad death. Agencies were asked to consider significant events prior to this timeline. The services provided to Child AK's siblings are included in the scope.

## The circumstances of Child AK's death

Child AK was born at full term with no additional needs. At the time of her birth, and discharge home, national restrictions remained in place as a result of the coronavirus pandemic. Child AK was four weeks of age at the time of her death. Mother had been caring for Child AK during the day and had attended a family celebration when she had consumed alcohol and smoked cannabis before sleeping in the same bed as Child AK that evening. A criminal investigation, commenced at the time of Child AK's death, concluded that no further action would be taken.

## The family

Child AK was born into a five-member family which included her mother, her two brothers (brothers 1 & 2) and two sisters (sisters 1 & 2). At the time of Child AK's death, brother 1 was fourteen, sister 1 twelve, brother 2 nine, and sister 2 was six. The children all have different fathers, these five fathers have been variously involved in caring for the children. The two youngest children in the family have additional needs, brother 2 is profoundly deaf,

---

[1] The definition of overlay: something placed on top of something else – in this case it was suspected that mother may have unintentionally laid over Child AK whilst they were asleep

[2] After notification of a significant safeguarding incident, local safeguarding children's partnerships may decide to convene a Rapid Reviews. The core functions of a RR is to; gather the facts about the case, as far as they can be readily established at the time, discuss whether there is any immediate action needed to ensure children's safety, share any learning appropriately and decide whether the criteria for a CSPR is met.

[3] An Open Conclusion is given where there is insufficient evidence to prove any other conclusion.

[4] *Working Together to Safeguard Children.* HMG 2018

[5] Bridget Griffin CQSW, BA, MA

and sister 2 has significant learning needs. Both have Education, Health and Care Plans (EHCPs).The family are white British, the extended family originate from Norfolk. The family live in an area of relative deprivation.

**Summary of multi-agency involvement**

There have been various multi-agency services involved in the lives of the children from a young age. Concerns about neglect in maternal care have been the focus of these concerns. There have been long standing concerns about the misuse of drugs and alcohol by mother, and some of the fathers, alongside concerns about maternal emotional wellbeing, 'physical chastisement' and domestic abuse. It was noted in the Rapid Review that these concerns have not altered from the original involvement of services, several of these concerns remain to date.

Multi-agency involvement over a period of at least ten years has been considerable and has included:

- Extensive pastoral support provided by the primary schools attended by the siblings – the breadth and depth of this support remains in place for brother 2 and sister 2 .
- Continuity of teaching assistants for brother 2 through his transition and attendance at a new primary school
- Significant support in place for brother 1 & sister 1 at their secondary school
- Various periods of involvement by Children's Services. Child protection or child in need plans have been in place at different times over the children's lives. Considerable support has been provided by various social workers and intensive family support workers. Children's services remain involved.
- Extensive support provided by teachers for the deaf, audiology and ophthalmology departments.
- Intensive speech and language support has been in place for brother 2 and more recently for sister 2
- Brother 2 and sister 2 have Education, Health and Care plans (EHCPs) in place and are provided with significant additional support to assist in their learning and development
- Health visitors, midwives and GPs have provided support throughout

The family have been in what has been described as *immense grief* since the death of Child AK. Extensive support has been provided to the family as whole, and to individual members, to support them in coping with this very significant bereavement. Bereavement support became the focus of multi-agency involvement for some time after Child AK's death.

## Key Themes

The key themes identified in this CSPR are set out using the terms of reference agreed by NSCP.

**1.To what extent did the multi-agency network understand, assess, and respond to neglect as a risk to this family, including to a newborn baby? What impact did neglect have on the children's lived experience?**

*Cumulative harm is a series or pattern of harmful events and experiences that may be historical, or ongoing, with the strong possibility of the risk factors being multiple, interrelated, and co-existing over critical developmental periods.*[6]

The Rapid Review describes this case as involving chronic neglect over several years and almost without exception, practitioners spoke about this being a family where the children have experienced long term neglect. Reviewing agency records, and speaking to practitioners as part of this CSPR, reveals the absence of a joint multi-agency understanding and approach to this family and little agreement about how to respond to the neglect the children have experienced. At the final stages of this CSPR, a joint multi-agency plan has been agreed. However, during this CSPR the case was progressing through the stages of the professional escalation process to reach an agreement about how to proceed. The reasons for this are varied. During this CSPR, the following factors have been identified as influencing the position that had been reached.

**1.1 Neglect is complex:** It is not that… *neglect is impossible to define, but that it cannot be defined in absolute terms. Like other forms of child maltreatment, neglect needs to be interpreted in context.* [7]

Nationally, it is well established that identifying, assessing, and responding to neglect remains challenging for multi-agency services. In responding to these challenges, multi-agency safeguarding practitioners have been supported by using an evidenced based practice model, and associated tools, to assess and respond to neglect. The preferred model in use nationally is the Graded Care Profile (GCP).[8]

The Norfolk safeguarding partnership promoted the use of the GCP in 2015: …*the GCP is a tool to complement professional judgment. Used as a multi-agency tool, it will contribute to well informed decision-making based on clearly understood and well articulated concerns across different disciplines.*[9] The GCP was adopted in Norfolk in 2016.

The GCP was not used to assess the neglect in this case, this meant that there was no shared multi-agency model used in responding to the children's needs. The result was drift, indecision and fragmented multi-agency working. Practitioners who had known the family over many years spoke about the 'start again syndrome' being a feature of assessment and decision making. They spoke about being trained in using the GCP but their experience of using the GCP was rare. They said that the GCP was inconsistently used in Norfolk and there were challenges to implementing the tool at the time, including understanding the roles and responsibilities of the multi-agency professional network in terms of who would complete the GCP. It was identified that this may be partly due to the frequent flux/changes in the social work workforce in Norfolk and it was said that these issues remain a barrier to achieving good multi-agency work.

In late 2019/early 2020 the Neglect Steering Group[10] reviewed use of the GCP and actively sought to learn from the experience of other Safeguarding Children's Partnerships in implementing this model. Learning from the experience of Hertfordshire, a revised GCP tool was adopted for use. During July – August 2021, 61 practitioners were trained in using the revised tool and a trial commenced. The recent GCP evaluation[11] revealed that 20% of the trial cohort had used the GCP and concluded that the inconsistent use of the GCP remained

[6] Psychology Developing practice: the child youth and family work journal 2007.P1 L. Bromfield, P. Gillingham, Daryl J. Higgins
[7] Child Protection and Introduction. Beckett 2007.
[8] The Graded Care Profile is an assessment tool that helps practitioners take a strengths-based approach to measuring the quality of care a child is receiving and supports them to identify neglect. The tool is licenced and promoted by the NSPCC.
[9] Barnardo's/Richardson July 2015. https://www.norfolklscb.org/wp-content/uploads/2016/07/GCP-Version-4.pdf
[10] Now known as: The Neglect Strategy Implementation Group (NSIG).
[11] Evaluating the Alternative Graded Care Profile trial – June 2022.

a concern. NSCP continues to endorse the use of the GCP when safeguarding children from neglect: *The [Partnership] has endorsed the use of the Graded Care Profile (GCP) as the assessment tool to be used in all cases where neglect has been identified. The tool should be used for assessment, planning, intervention and review.*

During the CSPR workshop involving members of the NSCP Priority Subgroups (Neglect & Protecting Babies), the GCP was discussed. The group recognised that some national challenges remain, particularly in relation to the consistent use of the GCP, but members of this group and the Panel were clear that *research shows that it works* and the benefits to children of using the GCP far outweigh the challenges. Several benefits of using the GCP were identified including:

- a consistent clear view of the family to be maintained which can mitigate the risks of staff turnover
- Helps to evidence issues / progress and measure progress.
- Helps to show cumulative harm – *makes neglect less nebulous*
- Helps to inform an effective plan and interventions
- Supports an understanding of cumulative neglect – maintains a cumulative composite organisational memory without which the view of the harm is compromised by being in the "here and now" – by responding to crisis
- *Neglect as a word creates noise in system and does not describe a child's experience of harm – without the GCP - there is an over emphasis on the parental voice and quick wins dominate practice*

**1.2 Understanding the risks posed by neglect requires the uniqueness of each child to be kept in view**

**Brother 1.** Brother 1 attends a local secondary school, he is fifteen. He is described as engaging well with school staff and no significant concerns have been identified. School staff have said that he has often been tearful and seeks support from trusted adults when needed, although he is not happy to share what is on his mind – he has written down that he often feels sick and describes as wanting to kill himself at the thought of coming to school although says he does not feel like this at home. In his history there has been an occasion of deliberate self–harm and concern about his sexual vulnerability. He is described by his school as lacking confidence in his ability. Brother 1 has received extensive support from both his primary and secondary school who have provided consistent and extensive support throughout his childhood.

**Sister 1.** Sister 1 attends a local secondary school, she is thirteen. She is described as engaging well with school staff. Earlier this year there were concerns about Sister 1 wandering out of lessons and punching walls and doors – this behaviour improved over time although recently she has been suspended from school. School staff have been concerned about periods of self-harm. Sister 1 is described as having a close group of friends who try and support her with her mental health needs. She has stayed with her father and his partner on occasions during her childhood. They described her as a quiet unhappy child who struggled to know how to play with her step siblings/family members – preferring to isolate herself in her room. Sister 1 has spoken openly about feeling responsible for Child AK's death – she described asking mother if she could care for Child AK when her mother attended the family event on the day of her death – she feels she should have made sure this happened.

**Brother 2:** Brother 2 is ten, he attends a local primary school. Brother 2 is profoundly deaf. He receives extensive support to assist him in his learning and communication and says: *I had an operation to have cochlear implants to help me hear. If I take off my cochlear implants, I can't hear anything, but I can feel noise vibrations. I am shy and always late for school.*

A multitude of concerns have been expressed by his primary schools throughout his childhood. These concerns primarily relate to the lack of care and attention paid by his birth family to his hearing needs – his cochlear implants have been regularly missing/damaged, and he has persistently not been taken to audiology appointments.[12] His mother and father have been repeatedly provided with opportunities to learn British sign language (BSL), but these opportunities have not been taken up - no one at home is able to communicate with brother 2. His development is delayed.

Brother 2 has been provided with extensive support by school staff and teachers of the deaf – he is supported at school throughout the day by teaching assistants who have been with him for many years, both communicate with brother 2 using BSL. He regularly describes being hurt at home; this seems to largely relate to the shouting that he says often happens – Brother 2 understands this shouting through the body language he observes. He has tooth decay and head lice – and describes the head lice as *spiders in my head.* Despite repeated and consistent attempts to support his birth family to successfully treat this infestation – there has been little success.

Brother 2 spends most of his time at home in his room playing games/accessing the internet and this has been a concern for the schools. He has described seeing dark shapes in his room and on one occasion described seeing a demon on the roof of the school. Brother 2 has recently started to hide in cupboards at school rather than attend his lessons. Throughout his childhood school staff have regularly raised concerns about the care he receives at home - consistent and persistent support is provided by school staff to meet his needs.

Brother 2 describes liking quiet places and needing people to communicate with him by one person talking at a time and by using visual aids – he does not like shouting – *loud noises hurt my ears.*

**Sister 2.** Sister 2 is eight, she attends the same primary school as brother 2. There have been consistent concerns about her cognitive development including her learning and speech and language and concerns about a chaotic home environment impacting on her emotional wellbeing/development. She is described as functioning two years below her chronological age. Sister 2 enjoys a close relationship with her paternal grandmother and stays with her and her father regularly – the care provided by paternal grandmother is regarded as good. Sister 2 says she wants her mother to *get better*[13] and that she wants to live with her paternal grandmother.

[12] School staff have ensured these appointments now happen in school when staff support Brother 2. .

[13] Sister 2 and her siblings have often referred to wanting mum to get better – by this they mean for her to *stop shouting and be happy.*

**Child AK.** Mother's pregnancy with Child AK was not planned and there was delayed contact with ante-natal services. During pregnancy, mother presented at hospital with vomiting and dehydration. Child AK's birth was uncomplicated and there were no concerns about any additional needs at birth. When Child AK and mother returned home, services had limited access to the family home as a result of the Coronavirus Pandemic. Consequently, her lived experiences were largely unknown to professionals. Her father described caring for Child AK at the maternal family home shortly after her birth - he described feeding, bathing and changing her and said he enjoyed undertaking these tasks and spending time with his daughter. Child AK was loved by her mother, father and siblings, who enjoyed having Child AK in the family and helped to care for her. Child AK was four weeks when she sadly died while in the care of her mother.

All the children in this family have been described by school staff as 'lovely' and 'delightful.'

Recent national reports[14] have set out the pressing need to understand the lived experiences of children. This is relevant to all children and is of particular importance when assessing how neglect may impact on these lived experiences. Throughout the children's lives, concerns have existed about; maternal emotional wellbeing, substance misuse, the impact of poor school attendance on the children's learning and development, the lack of parental attendance at professional meetings, children not brought to important appointments relating to their health, wellbeing and development, use of 'physical chastisement' and a chaotic home environment (which has included various household visitors and episodes of domestic abuse).

It has been, and is, widely acknowledged that the children in this family have a history of adverse life experiences attributable to *chronic low-level neglect*. It is clear there has been extensive support provided by multi-agency services, in particular schools, to fill the gaps in the parenting they have received at home to meet their needs. The question that has perpetually arisen, and has been the subject of professional disagreement, is: When should a higher threshold of intervention be used to safeguard the children? This question can only be answered by an evidence-based assessment that considers the unique needs of each child in the family and the specific impact of neglect on each child.

**The impact of neglect on adolescents.** There is extensive research[15] about the impact of long-term neglect on children which suggests that whilst a child's experience of neglect may not be serious enough to take statutory action in their childhood's - the longer-term outcome can manifest in behaviors seen during adolescence, which is shown to include mental health difficulties, poor academic achievements, substance misuse, and can increase the risk of sexual and/or criminal exploitation.

**The impact of neglect on younger children.** Research about the impact of neglect on young children widely accepts that it has the potential to compromise the developing brain and a child's development across a range of domains.[16] It is also widely accepted that with the right kind of support from services, the extent of the impact on a child's development can be reduced - persistent and consistent support has the potential to build resilience and improve outcomes. However, whilst there are some basic needs that are common to all children, as stated earlier, the unique needs of each child and the impact must be in clear view. Assessments and interventions must consider these unique needs by considering the

---

[14] Such as: *Annual Report 2020 Patterns in practice, key messages and 2021 work programme.* Child safeguarding practice review panel 2021. *The case for change - the independent review of children's social care*. Josh Mc Alister May 2022.
[15] Understanding Adolescent Neglect: Troubled Teens A study of the links between parenting and adolescent neglect. November 2016. The Children's Society. CORE-INFO: Neglect or emotional abuse in teenagers aged 13-18. NSPCC. https://www.norfolklscb.org/wp-content/uploads/2015/05/core-info-neglect-emotional-abuse-teenagers-13-18.pdf. That Difficult Age: Developing a more effective response to risks in adolescence: Evidence Scope (2014). Research in Practice
[16] https://learning.nspcc.org.uk/child-health-development/childhood-trauma-brain-development.

age, stage of development, gender, position in the family, any additional needs and how each child uniquely feels the experience of neglect. Brother 2 and sister 2 have significant additional needs. The impact of neglect on their childhood experiences, on short and long-term outcomes, is unique.

**The impact of neglect on babies.** The risks to babies living in a household where neglect is a feature are unique. For older children, with no additional health needs, the risks are predominantly around short and long terms outcomes in health, wellbeing, and development. In households where there is a large sibling group, there is a risk that the unique risks to a baby can be minimised or overlooked. For babies, because of their complete dependency on care givers, the risks of living with neglect can be fatal. [17]

Throughout this CSPR practitioners have spoken about the existence of *low-level chronic neglect* in this family but several struggled to articulate what this meant for each child. Ante-natal and post natal services seemed aware of the neglect and, when the risks of physical harm were discussed during this CSPR, these risks were understood. Parental education about household risks and safe sleeping were often discussed with mother[18] but the risk of physical harm (resulting from domestic abuse, chaotic care giving, and a mother who used drugs and alcohol) was not raised within the multi-agency group as a specific concern about the potential of physical harm to a baby.

**Conclusion:** Sadly, this CSPR was commissioned as a result of the death of a baby. Her death has led to a systemic overview of the harm the siblings have experienced and the services provided that may not have happened if a CSPR had not commenced. The pattern of multi-agency responses to the neglect in this case was characterized by responding to incidents of acute concern when they arose. Each period of intervention by Children's Services appeared to be influenced by the view that this was a family known well and the parenting was seen as *not quite good enough but not quite bad enough* to lead to higher thresholds of intervention. The risks were not viewed through a lens that considered the changing context and dynamics of the risks within the family as they evolved. The Rapid Review highlighted that the overall pattern/ history of the children's experiences was not considered in weighing the risks, and there was *a repeated syndrome of starting again.* As identified in national reports and in relevant CSPRs/Serious Case Reviews,[19] this kind of approach to neglect is not specific to Norfolk. This CSPR has highlighted that the lack of an assessment using an evidence-based model/approach was the root cause.

Finally, the perspective of parents/carers in these circumstances is critical. The children's mother experienced many years of service intervention in family life; multiple practitioners were involved, and multiple tasks were set. Without a clear assessment about what needed to happen to achieve long term change; what were the priorities, what were the timescales and what were the consequences, it is perhaps reasonable that change has been difficult to achieve. Mother's views are that she is thankful for the services that have been provided and that she could not have parented the children without them. However, she also described the multitude of services, practitioners, plans, tasks, and appointments as - *overwhelming.*

A relevant Joint Targeted Area Inspection[20] recommends a coordinated and strategic approach across all agencies and that both adult and child focused services need to look holistically at the whole family. At the learning workshop, members of the Protecting Babies subgroups in Norfolk identified that this approach is needed in Norfolk.

---

[17] The Role of Neglect in Child Fatality and Serious Injury. Marian Brandon, Sue Bailey, Pippa Belderson, Birgit Larsson. First published: 27 August 2014.

[18] Considerable work has been completed in Norfolk as part of the Protecting Babies Strategy to promote safer sleeping; Just One Norfolk provides easily accessible consistent messages; safer sleeping and the risks of co-sleeping have been made with parents and workforce training provided

[19] Such as : *Serious Case Review Hakeem.* Birmingham Safeguarding Children's Partnership 2022

[20] *Growing up neglected: a multi-agency response to older children.* Joint Targeted Area Inspection. Ofsted. July 2018

**Recommendation 1.**
The revised Norfolk GCP must be used in cases of neglect with strong multi-agency leadership to ensure effective implementation. This should include agreeing clear roles and responsibilities for completing the Norfolk GCP in any safeguarding/care plan. Audit of neglect cases from across the child's journey to test effective implementation and assess how it impacts on planning and interventions within 12 months of publication.

**Recommendation 2.**
Babies born into large (4+) sibling groups receiving interventions should be recognised as increasingly at risk; this should cover Early Help Assessments, Family Support, Child in Need and Child Protection Plans. This specific risk should be written into the Norfolk Threshold Guide. Risks should be made clear in records and tested through a dip sample audit within 12 months of publication.

**2. Was there sufficient understanding of the family dynamics and the role of the fathers in the children's lives? How well were they engaged and what support did they provide in the care of their own children and the family as a whole?**

The previous section has outlined how the evolving needs in the family were not considered as part of a dynamic risk assessment that considered the unique needs of the children. It is however important to recognise that a valid challenge to intervening in family life at a high level of threshold intervention in cases of neglect, such as legal proceedings, is that the current options available in state care for improving outcomes for children are poor.[21] This poses challenging dilemmas for children's social care and multi-agency services. However, it is important to move away from considering the options for children in binary terms (such as a child remaining at home with parents or removal into state care) and find flexible and creative solutions with the support of extended family and kinship. Josh MacAlister describes this as *unlocking the potential of family networks* and *building a loving tribe.*[22]

At the start of this CSPR, NSCP were keen to reflect on the local safeguarding landscape in light of the report published by the Child Safeguarding Practice Review Panel[23] highlighting the lack of involvement by services with fathers/male care givers in the lives of children. Information was gathered from all agencies involved in this review to understand how much was known about the fathers and how much contact was had with them. It is clear from the information provided that whilst the fathers were known about, there was little information in agency records about the relationship with their children and contact details were rarely documented.

During this CSPR, mother has been described as a 'single mother.' Describing, and perceiving, mother as a single carer has largely dominated agency records, the narrative of practitioners and discussions in panel. This description has been challenged on the basis that it is widely known that all the children have different fathers, all of whom have had some form of contact with their children. Some of the children have spent significant periods of time in their care, and at least two of the fathers have shown an ability to provide effective care. Four of the fathers were keen to share their perspectives as part of this CSPR.

---

[21] *The case for change – independent review of children's social care*, J. MacAlister 2021
[22] *The case for change – independent review of children's social care*, J. MacAlister 2021
[23] "The Myth of Invisible Men" Safeguarding children under 1 from non-accidental injury caused by male carers Child Safeguarding Practice Review Panel. September 2021

In Norfolk, Family Networking is described as an integral component to Signs of Safety[24] practice, which involves delivering care and support through extended family networks. *We know that young people grow more resilient and are more likely to achieve better outcomes when they have the support of a naturally connected network, yet this is one of the most underdeveloped areas in safeguarding.* Family Network training has been provided to the workforce to provide search and engagement tools that both build and strengthen important connections for young people and their networks.

In this case, Family Networking has not been successfully used to achieve the involvement of fathers and the extended family. A family group conference has attempted to include the extended maternal family (who mother has described as critical in supporting her care of the children) although this has proved problematic. It is understood that fully involving fathers in these meetings has been complicated to achieve and therefore has not yet been successful. Fathers have spoken about being involved in their children's lives for many years but of not knowing what services have been involved or the nature of the concerns held. They spoke about not knowing what was expected of them/what they needed to do in order to – in the words of a father – *co-parent their child,* and how they might be supported to do so.

Overall, what has emerged chimes with national findings: *Many of the issues explored here reflect deeply engrained roles, stereotypes and expectations about men, women, and parenthood in our society. Notwithstanding major social changes, women continue to be regarded as the prime and sometimes only protective carer for their children…... The report also takes stock of how well safeguarding and other services engage with men. It sets out systemic weaknesses in the way that universal and specialist services operate. Too often, even if unwittingly, they enable men to be absent.*[25]

**A cultural shift is needed:** *Cultural change is never easy to achieve. It means taking an organisation-wide approach to including fathers and working with other agencies and joining up principles; it means starting with a belief that fathers matter too, and engaging them in the early years sector, schools, social services and health services.*[26] The view of the CSPR Panel is that this statement should read fathers are equally important and that including father's should be *a mantra of safeguarding practice* - this is the cultural shift Norfolk is aiming for.

The NSCP is responding to the Myth of Invisible Men report with a dedicated project lead to implement a three-year father inclusive strategy across the whole partnership to raise the visibility of fathers and improve the engagement of fathers in Universal, Early Help and Specialist Children's Services. This strategy is taking a systemic approach using the four-tier model identified in the report to help improve the engagement and assessment of fathers and father figures as well as the support and challenge that is offered to them.

**Recommendation 3.** The NSCP should produce and promote sector specific good practice guides on working with fathers and father figures and good practice in working with them, highlighting the expectations of all partner organisations around professional curiosity, engaging, assessing, recording and information sharing when working with all families.

[24] The Signs of Safety® approach is a relationship-grounded, safety-organised approach to child protection practice, created by researching what works for professionals and families in building meaningful safety for vulnerable and at-risk children.

[25] *"The Myth of Invisible Men"* Safeguarding children under 1 from non-accidental injury caused by male carers. The Child Safeguarding Practice Review Panel September 2021.

[26] www.fatherhoodinstitute.org- The risks of excluding fathers.

**3. Was the history of domestic abuse fully explored and understood in terms of the impact on the sibling group?**

In the history of this family there have been incidents of domestic abuse. However, according to agency records, these incidents were not frequent. The children have been recognised as victims and provided with regular opportunities to speak about life at home, their testaments show that their experiences are not of frequent domestic abuse but of a volatile household where there are often arguments and 'shouting.'

When domestic abuse incidents have occurred, these have been responded to by providing services to the children's mother, and more recently to a father, and safety planning has taken place for the children. Recently, practitioners have identified a suitable specialist service for brother 1 and sister 1 to explore the impact of this domestic abuse and referrals have been made. However, the siblings have not accessed these specialist services. The reasons are multiple including the high level of needs in the family requiring the involvement of multiple services, the difficulty in securing engagement from mother, the ongoing cycle of service response to crisis and the recent death of Child AK.

During this CSPR it was clear that practitioners understood the impact of domestic abuse on children and the recent work completed by the family support team and the emotional wellbeing support provided in schools has provided avenues for the children to speak about the impact of their lived experiences. Providing frequent opportunities for children to reach out to adults they trust to speak about their emotional worlds is in line with trauma informed practice. In cases such as this, it is a pragmatic response that fits with evidence-based practice.[27]

**4. How was the risk of physical harm understood in the family?**

The risk of physical harm to Child AK because of neglect has been discussed previously. According to the records, and to practitioners, the risks to Child AK's siblings of physical harm stem from the use of 'physical chastisement.' There are historical agency records detailing incidents of what has been termed 'physical chastisement,' one significant incident reported by brother 1 was concluded to be an incident of 'physical chastisement' although was not fully investigated. There have been later disclosures by brother 2 and sister 2 of being slapped and pushed by mother. Services were too quick to conclude these to be incidents of 'physical chastisement' with no clear rationale documented to show how these conclusions were reached. It is understood that there continues to be incidents of 'physical chastisement.' The reasoning behind the conclusion of 'physical chastisement' rather than physical abuse is now clearer, and work has been completed with mother by children's services to improve her parenting and avoid resorting to 'physical chastisement' as a way of disciplining the children.

Understanding and responding to the use of 'physical chastisement' by carers continues to be an area that presents challenges to the children's workforce. Knowing how to assess the risks to children and how to respond has been raised in Serious Case Reviews/Child Safeguarding Practice Reviews.[28] This confusion is not helped given that it is not completely outlawed under current legislation given that for criminal prosecutions for assault there is a defence of reasonable chastisement.

This year Wales joined Scotland and 60 other countries across the world in no longer tolerating any physical violence against children, in the same way they don't for adults.

---

[27] *Trauma-informed responses in relationship-based practice.* Danny Taggart 2018. https://www.researchinpractice.org.uk/children/news-views/2018/june/trauma-informed-responses-in-relationship-based-practice.
[28] NSPCC Repository. https://learning.nspcc.org.uk/case-reviews.

The argument that England should follow suit has recently strengthened in recognition of the growing research that physical chastisement is linked to increased aggression in children, greater tolerance of violence and compromises a child's development and wellbeing.

*Having reviewed 20 years of research on physical punishment, we can unequivocally say that the evidence is clear: physical punishment is harmful to children's development and wellbeing.*[29]

| **Recommendation 4.** NSCP to write a position statement about 'physical chastisement' and substance misuse and be clear about how to promote and endorse these statements in practice. |
|---|

**5. How were the risks around substance misuse understood and addressed with the mother, fathers, and wider family network?**

Mother is described as 'open' when talking about her depression and her drug and alcohol use. In discussion with mother as part of this CSPR she was asked if she has understood what changes she needed to make in the parenting of her children. She was quick to identify that she needed to change her 'drug habit' and referred to the good work now being completed by The Matthew Project[30] with brother 1 and sister 1. Services have been provided to a father, who is in regular contact with the family, to address drug use and it seems there is now a focus on mother's drug use. It has been reported that mother has said that this is used to 'self medicate.' It has been suggested that mother's drug use has been exacerbated by the tragic loss of Child AK.

Practitioners were all clear that substance misuse has been an issue in the family for some time. However, prior to this point, there seemed to be little attention paid to the extent and impact of substance misuse on the mother, the fathers, the children, the family dynamics, and household functioning. Whilst the question posed by the terms of reference suggests that substance misuse by the wider family was an area of concern, little has been seen to suggest that this has been explored.

References made by professionals to mother 'self medicating' on class A and B drugs, including her own disclosures, require further thought. Framing drug use in this way can enable open discussions to be had about use and perhaps reduces the shame that can often accompany the use of drugs that can perpetuate the cycle of addiction. This is an understandable and well researched[31] way to work with addiction. However, when safeguarding children, of central importance is the need to appreciate the impact of drug misuse on them. This has not received sufficient attention in the past and is illustrated in the substance misuse by mother and sister 2's father when caring for Child AK prior to her death.

As identified earlier, neglect commonly poses a constellation of risks to children which can include living in households where carers are misusing substances. The Panel felt that this is something that can be normalized and rarely something that, in isolation, reaches a threshold for immediate intervention. The pressure on resources and the volume of demand

[29] Dr Anja Heilmann, UCL Department of Epidemiology and Public Health https://www.nspcc.org.uk/about-us/news-opinion/2022/equal-protection-wales-england.
[30] The Mathew project is a community organisation based in Norfolk that undertakes work with parents and children who are effected by drug use.
[31] https://www.nhs.uk/live-well/addiction-support/drug-addiction-getting-help/
*The shame of addiction.* Owen Flanagan. Department of Philosophy, Duke University, Durham, NC, USA 2013.

placed on safeguarding services can lead to multi-agency services addressing each risk when it emerges as an acute need. Research suggests that children are harmed by the cumulative nature of neglect which can include living in families where there is a chronic misuse of substances. The sheer complexity of assessing and responding to neglect in a system that is set up and proficient in safeguarding a child from immediate harm means that providing a response to the constellation of harm posed to children of *chronic low-level neglect* can risk being delayed.

**Conclusion:** Children living with carers who misuse substances are likely to live through a continuum of experiences including - an inconsistent response to their needs and/or daily life that features a volatile and neglectful carer whose behavior is erratic, fearful, and difficult to predict. As stated previously, neglect is a constellation of risks - substance misuse may form part of this constellation as it did in this case. To assess the impact on children's lived experiences, and intervene effectively, an evidenced based assessment framework is needed. The Graded Care Profile assessment framework and associated tools provide an opportunity to provide an effective response.

**Recommendation 5.** Professionals working with pregnant mothers and fathers-to-be should be mindful of the extent of current and historic substance misuse and the impact on the unborn child as well as any existing sibling groups. This should include financial impact, parental ability to regulate mood and neglectful and/or emotionally abusive parenting. The Norfolk GCP should be used in response to these cases to measure impact over time and should be incorporated into the GCP audit.

**6. What impact did work under Covid-19 restrictions have on the interventions put in place, the professionals' ability to risk assess and the mother's and fathers' compliance?**

The scope of this CSPR has covered a period when national restrictions were in place as a result of the coronavirus pandemic. In summary, in August 2020 lockdown was in the process of easing – leisure and recreational facilities were re-opened. In October 2020, a second national lockdown commenced for four weeks – this eased but was followed by tier four restrictions coming into force towards the end of December 2020. This eased over the following months and by July 2021 all restrictions were lifted. Multi- agency services were clearly affected by the pandemic; some services were restricted; schools were only open to children classed as vulnerable, some workers were shielding, and home working was well established.

The universal impact of the coronavirus on children and families has now been well documented, and the fact that the pandemic deepened existing inequalities (according to ethnicity, age and economic status) is well known. The family in this case live in an area of relative deprivation. There is no doubt that the pandemic compounded existing economic hardship and restricted access to resources. Inequality, resulting from living in a low-income household, remains a feature of the children's lived experiences. In terms of service provision, it is clear that all services were flexible and creative in the ways the family were supported and the restrictions in place did not have a discernible impact on the ability of professionals to assess the risks. These risks were well known before the pandemic started.

It is clear that professionals often struggled to access the home and the pandemic was often cited by mother as a reason why the children could not attend school, why appointments were not kept or why professionals could not access the home. In this climate, it is

reasonable to assume that these reasons may have been valid - the pandemic was a context within which compliance could not be reliably assessed.

For the purposes of this CSPR the key question is how 'compliance' was assessed and measured over time. As previously described, fathers were not held in view – their compliance was neither requested nor the subject of assessment. All practitioners have referred to a long history of 'disguised compliance' by mother. When practitioners were asked what this meant, it seemed to equate to mother agreeing to plans, decisions, goals and tasks but not following these through. This remains a concern to current practitioners and is given as the prime reason why progress has not been made in time for the children.

As identified by members of the NSCP Protecting Babies subgroups, there are risks associated in using terms such as 'disguised compliance'. The term in itself is felt to be a message to families reinforcing where the power lies in their relationship with services and, without a full assessment of what is getting in the way of services securing the engagement of families, using the term in isolation is of little use.

The views of panel members were that using this term has become an accepted part of the safeguarding language; it is a term that is commonly used but conveys little meaning. In this case, there was no meaningful engagement. The view of panel members was that the nature of engagement should be described, and the extent of engagement measured exclusively on the outcomes for children.

*Language fills the void created in the absence of an effective evidenced based tool.*[32]

| **Learning Point: Understanding a child's world - paying attention to the language we use.**<br><br>Realities are socially constructed, constituted through language,<br>and organised and maintained through narrative - *Communication is the creation and exchange of meaning.*[33]<br><br>The use of language by services, practitioners and managers has been an area identified by the NSCP Protecting Babies subgroup and panel members as requiring attention. It has been highlighted that certain terms or words can frequently be used in safeguarding work and a shared meaning assumed. The examples in this case were the terms 'physical chastisement' and 'disguised compliance'. Another example cited by panel was using the term 'good/poor attachment'. The importance of understanding a child's lived experience by describing what is being observed was emphasised – doing so provides an opportunity to get beneath the surface to the heart of a child's world - this correlates with the findings from national reviews.[34] |
| --- |

## Conclusion

This CSPR has identified service changes are needed when safeguarding children from neglect. However, it is important to note that had all these services been in place at the time, there is no guarantee that Child AK would be alive today.

---

[32] Member of the Protecting Babies Subgroup NSCP
[33] From the work of M White & D Epston
[34] Such as : *Child Protection in England.* The Child Safeguarding Practice Review Panel 2022

The support provided by services to this family have been immense. Mother has said how thankful she is for the support that has been provided. She is clear that without this support she would not have been able to care for her children. This case is a testament to the incredible work of schools in Norfolk, the work of health professionals, and to the recent services provided by children's services that have filled the gaps in parental care. Throughout the years of intervention there have been times when there has been multi-agency disagreement about the level of statutory intervention needed to safeguard the children. During this CSPR, these professional differences have been resolved.

A great deal of work has been completed to support mother to care for the children at home, some of this work has been successful. However, the lack of an evidenced based assessment at an early point, and throughout service intervention, contributed to a position that was reached which appeared to be binary – either the children should remain at home, or the children should be provided with state care. The positions taken on both sides of the multi-agency split that existed were reasonably informed by research - the outcomes for children in state care are poor and the children's lived experiences of living with neglect are reasonably predicated to result in poor outcomes. The history shows that opportunities to take a robust approach to safeguard the children from neglect have been lost. This includes the effective assessment of the whole family network and particularly the assessment, support and challenge offered to the fathers. It is therefore perhaps understandable why a binary position was reached.

To the credit of the multi-agency group, and use of an innovative multi-agency forum (Joint Agency Group Supervision) in Norfolk,[35] creative and flexible approaches have now been negotiated across the multi-agency safeguarding system that fully considers the children's needs in the short and long term and galvanises the multi-agency network, family, kinship and trusted adults to find a way forward.

**Learning point – Joint Agency Group Supervision (JAGS)**

In responding to learning from Serious Case Reviews/CSPRs, NSCP established multi-agency supervision forums known as JAGS. The purpose of JAGS across partner agencies is to provide a mechanism to reflect on cases which are very complex, including – but not exclusive to - cases which feel 'stuck', or are drifting.

*Joint supervision provides a reflective space for joint analysis of assessment information, an opportunity to explore what professionals know about the lived experience of the child and should help strengthen the relationship between professionals who are working together with families to secure the best outcomes for children.*

These forums are regarded by practitioners as a positive development that strengthens their work together. It was felt important to raise the profile of JAGS in Norfolk so that they continue to underpin multi-agency work and provide an opportunity for other areas to learn from NSCP experiences of developing such an important forum.

[35] https://www.norfolklscb.org/about/policies-procedures/3-16-joint-agency-group-supervision-procedure/

**Summary of Recommendations**

**Recommendation 1.** The revised Norfolk GCP must be used in cases of neglect with strong multi-agency leadership to ensure effective implementation. This should include agreeing clear roles and responsibilities for completing the Norfolk GCP in any safeguarding/care plan. Audit of neglect cases from across the child's journey to test effective implementation and assess how it impacts on planning and interventions within 12 months of publication.

**Recommendation 2.** Babies born into large (4+) sibling groups receiving interventions should be recognised as increasingly at risk; this should cover Early Help Assessments, Family Support, Child in Need and Child Protection Plans. This specific risk should be written into the Norfolk Threshold Guide. Risks should be made clear in records and tested through a dip sample audit within 12 months of publication.

**Recommendation 3.** The NSCP should produce and promote sector specific good practice guides on working with fathers and father figures and good practice in working with them, highlighting the expectations of all partner organisations around professional curiosity, engaging, assessing, recording and information sharing when working with all families.

**Recommendation 4.** NSCP to write a position statement about 'physical chastisement' and substance misuse and be clear about how to promote and endorse these statements in practice**.**

**Recommendation 5.** Professionals working with pregnant mothers and fathers-to-be should be mindful of the extent of current and historic substance misuse and the impact on the unborn child as well as any existing sibling groups. This should include financial impact, parental ability to regulate mood and neglectful and/or emotionally abusive parenting. The Norfolk GCP should be used in response to these cases to measure impact over time and should be incorporated into the GCP audit.

.