Norfolk Safeguarding Children Partnership

Learning from Safeguarding Practice Reviews

Case AK

Safeguarding Practice Review: Case AJ

This presentation sets out:

- Summary of the case
- Process and methodology
- Children's Profiles
- Areas of Learning & Recommendations
- The NSCP's response
- Learning Activities

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Summary of the Case

- Child AK: baby born into family with four older siblings – age range of sibling group adolescent to newborn
- Each child had a different father; all fathers involved in their child's life
- History of interventions due to concerns about neglect
- Open to Children's Services on Child in Need Plan when mother became pregnant in 2021 – during pandemic
- AK died at 6 weeks of suspected overlay – coroner's verdict was open, acknowledging that co-sleeping could have been a contributory factor but this could not be said for certain
- Police have not charged

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Summary of the Case: Neglect Concerns

- Late booking of pregnancy and lack of engagement with HV post and antenatally
- Long history of CS involvement – historic concerns were not always fully considered in terms of risks to children
- Parental drug/alcohol misuse and Maternal mental health
- Lack of engagement and disguised compliance
- Physical neglect and ‘chastisement’ of all children
- Poor school attendance
- Multiple A&E attendances – gastrointestinal symptoms – no clear diagnosis
- Missed health appts for all children
- Extensive criminal history of fathers involving drugs and violence
- Volatile relationships in household
- Lack of child focus when they have said worrying things about what is happening at home
- Poor evidence of Multi-Agency work /silo working
- Start again syndrome evidenced in records lack of consideration of historical functioning
- Some professionals overly optimistic
- Lack of effective escalation

Summary of the Case, cont.

- Surviving siblings remained in the care of mother during police investigation and while case was under review
- Many of the issues identified prior to and following AK's death were still prevalent during review
- Professional differences resolved through Joint Agency Group Supervision at end of process

Process and Methodology

- Rapid Review and integrated chronology
- Terms of Reference agreed
- Review Panel made up of senior managers from agencies involved.
- 1-2-1 reflective conversations held with practitioners
- Family involvement: conversations with mother and four out of five fathers (one chose not to be involved), including two face to face meetings
- Learning Event with NSCP Priority Subgroups – Neglect & Protecting Babies – strategic leaders/senior managers
- Report signed off by statutory partners
- Reflective learning session held to share report with practitioners directly involved prior to publication

Children's Profiles

Brother 1, age 15.

- attends a local secondary school
- 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 wanting to kill himself at the thought of coming to school although says he does not feel like this at home.
- there has been an occasion of deliberate self–harm and concern about his sexual vulnerability.
- escribed by his school as lacking confidence in his ability.
- primary and secondary school have provided consistent and extensive support throughout his childhood.

Sister 2, age 13.

- attends a local secondary school
- described as engaging well by school
- earlier this year there were concerns about 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.
- described as having a close group of friends who try and support her with her mental health needs.
- 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.
- feels responsible for Child AK's death – offered to care for Child AK prior to incident leading to death

Children's Profiles, cont.

Brother 2, age 10

- attends a local primary school.
- is profoundly deaf. He receives extensive support to assist him in his learning and communication, e.g. dedicated teaching assistants who sign
- lack of care and attention paid by his birth family to his hearing needs: his cochlear implants regularly missing/damaged; persistently not been taken to audiology appointments; parents have been repeatedly provided with opportunities to learn British sign language (BSL), but these opportunities have not been taken up
- his development is delayed.
- he regularly describes being hurt at home; this seems to largely relate to the shouting that he says often happens – understands this shouting through the body language he observes.
- 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.
- spends most of his time at home in his room playing games/accessing the internet
- has described seeing dark shapes in his room and on one occasion described seeing a demon on the roof of the school.
- describes liking quiet places and needing people to communicate with him by one person talking at a time and by using visual aids *loud noises hurt my ears.*

Children's Profiles, cont.

Sister 2, age 8

- attends the same primary school as brother 2.
- consistent concerns about her cognitive development including her learning and speech and language
- concerns about a chaotic home environment impacting on her emotional wellbeing and development.
- described as functioning two years below her chronological age.
- 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; she wants to live with her paternal grandmother.
- says she wants her mother to *get better* and – by this she means for her to *stop shouting and be happy.*

Child AK.

- Mother's pregnancy was not planned; delayed contact with ante-natal services.
- During pregnancy, mother presented at hospital with vomiting and dehydration.
- birth was uncomplicated and there were no concerns about any additional needs at birth.
- At discharge, services had limited access to the family home due to Covid; 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.
- AK was loved by her mother, father and siblings, who helped to care for her.
- was four weeks when she sadly died while in the care of her mother.

The Learning - Neglect

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?

- Rapid Review and practitioners spoke about chronic long term neglect over many years
- No joint multi-agency understanding and approach and little agreement about how to respond to the neglect the children experienced - drift – starting again
- Non – school attendance, 'physical chastisement', substance misuse, domestic abuse, volatile and chaotic home: health & wellbeing not promoted and parental non – engagement ('disguised compliance')
- Uniqueness of the children's needs & evolving risks not understood within context

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The Learning – Neglect, cont.

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.* (Beckett 2007)

- A national challenge – for services and practitioners
- Supported by evidenced based assessment and planning tools
- Graded Care Profile (GCP – neglect assessment tool) endorsed by use by NSCB in 2016; it was inconsistently used – not used in this case.

"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." (Member of Protecting Babies Steering Group)

The Learning – Neglect: 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 Norfolk Threshold Guide. Risks should be made clear in records and tested through a dip sample audit within 12 months of publication.

The Learning – Family Dynamics & Fathers

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?

- Family dynamics and evolving needs not understood
- Fathers were known about: there was little information in agency records about the relationship with their children and contact details were rarely documented.
- At least 2 of these fathers have adequate parenting skills.
- *"I did not know how to co-parent my child."* (Sister 2 Father)

The Learning – Family Dynamics & Fathers: Recommendation

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.

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The Learning – Impact of Domestic Abuse

Was the history of domestic abuse (DA) fully explored and understood in terms of the impact on the sibling group?

- Sporadic DA that was responded to – services provided to mother and a father
- Specific services offered to eldest siblings – who were not brought to appointments for follow up
- Most importantly – the children's experience of a volatile & chaotic household, including substance misuse with adult visitors they did not feel safe with, but…
- …Children formed trusting relationships with some professionals and had opportunities to speak about life at home – evidence of trauma informed practice

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The Learning – Risk of Physical Harm

How was the risk of physical harm understood in the family?

- Risk of physical harm to Child AK not understood
- Risk to the children was of physical and emotional harm as a result of ‘physical chastisement’
- Too quick to conclude incidents of physical harm was a result of ‘physical chastisement’ and little consideration of longer term impact
- Research clear about long term harm
- The law stating that chastisement can be reasonable is unhelpful

The Learning – Substance Misuse

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

- Long standing substance misuse by mother and by some of the fathers
- A service provided to a father after Child AK's death
- Impact of maternal substance misuse on the children not assessed/not in view
- The pressure on resources and the volume of demand 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 Learning – Physical Harm & Substance Misuse: Recommendations

Recommendation 4.

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. The NSCP should consider what communication campaigns and or training is required to raise awareness of the impact of substance misuse.

Recommendation 5.

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.

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The Learning – Covid-19

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?

- Scope of this CSPR covered a period when national restrictions were in place
- Services were flexible and creative in response – no discernible impact on assessing risks
- Risks were not understood therefore risks were not in sight
- Fathers 'compliance' was not requested and therefore not assessed
- A long history of 'disguised compliance' – what did this mean?
- Prime reason for lack of progress

The Learning – Covid-19, cont.

‘Disguised Compliance’ – paying attention to language

The views of panel members were that using this term has become an accepted part of the safeguarding language that is commonly used but conveys little meaning.

- The use of language by services, practitioners and managers has been an area identified 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 sighted 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.

Other Learning Points

More on language:

- Realities are socially constructed, constituted through language, and organised and maintained through narrative - *Communication is the creation and exchange of meaning.* (M White & D Epston)

- *Language fills the void created in the absence of an effective evidenced based tool.* (Member of Protecting Babies Steering Group)

Joint Agency Group Supervision (JAGS)

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. They were influential in the final outcome for AK's sibling group.

NSCP's Response

- Neglect remains an NSCP Priority and the strategy is being refreshed as a result of this SPR and other learning. With this:
    - Recommendations from the SPR have been shared with the NSCP's Neglect Strategy Implementation Group
    - An Accumulative Neglect Operational Oversight Group will be established to maintain oversight of longitudinal neglect and monitor the impact of interventions over time
    - The Norfolk Graded Care Profile has been updated and a robust implementation plan is in place to support the workforce and build their confidence in using the NGCP in practice
    - Audit work on children on Child Protection Plansfor second or subsequent time in large sibling groups currently in progress. Audit on measuring interventions born into babies where neglect is an issue in forward plan.
- The NSCP are developing a position statement on both 'physical chastisement' and substance misuse with a focus on children's lived experience and understanding impact
- The NSCP's three statutory partners have invested in a dedicated project lead to improve the way we work with fathers and men. This will incorporate Think Family approach and build on existing training around Family Networking.
- The Threshold Guide is under revision and will take account of learning from this SPR.
- Learning from this review will be disseminated through SPR roadshows, spring 2023

Learning Activities

- Consider how you/your team assesses and understand the impact of neglect on individual children. What are the challenges of working with larger sibling groups and how do you overcome them?

- Have you accessed training for the Norfolk GCP? How can you use this tool in practice?

- Discuss your use of language. What terms do you use as shorthand? How do you test your thinking and/or colleagues' understanding of terminology? How well do you accept and provide challenge both professionally and in direct work with challenge when thinking about language?

- How well do you work with fathers? How do you gather and share information about fathers and keep them informed of concerns? What are the barriers & opportunities?

- Take up opportunities for Joint Agency Group Supervisions to enable reflective thinking and feedback to your team on how it worked and what perspective it gives you on complex cases