

Local Child Safeguarding Practice Review

“Julie”

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&

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# **Introduction and Rational for the Safeguarding Practice Review**

Under Working Together 2018 statutory guidance, the Tower Hamlets Safeguarding Children Partnership agreed to undertake this Child Safeguarding Practice Review following completion of a Rapid Review which concluded that there was the potential to identify national and local learning.

*“The purpose of reviews of serious child safeguarding cases, at both local and national level, is to identify improvements to be made to safeguard and promote the welfare of children. Learning is relevant locally, but it has a wider importance for all practitioners working with children and families and for the government and policymakers. Understanding whether there are systemic issues, and whether and how policy and practice need to change, is critical to the system being dynamic and self-improving.*

*Serious child safeguarding cases are those in which:*

* *abuse or neglect of a child is known or suspected and*
* *the child has died or been seriously harmed*

*Serious harm includes (but is not limited to) serious and/or long-term impairment of a child’s mental health or intellectual, emotional, social, or behavioural development. It should also cover impairment of physical health. This is not an exhaustive list. When making decisions, judgment should be exercised in cases where impairment is likely to be long-term, even if this is not immediately certain. Even if a child recovers, including from a one-off incident, serious harm may still have occurred.” [[1]](#footnote-1)*

**Case Summary**

The report reviews the case of Julie and identifies system learning. Julie is an infant who suffered two serious head injuries on two separate occasions due to falling off a bed, both of which required hospitalisation. Names have been changed throughout to protect identities.

**Methodology and Agencies Involved**

This review has been carried out in a way that reflects the principles of a systems-based approach.

The review seeks to understand why things happened in the way that they did. Broadly this means using this case as a ‘window on the system’, asking the question: ‘What does Julie’s experience tell us about how systems work and how it needs to change?’

The aim is to look for areas that relate to systemic issues, which will lead to changes in practice. The focus of this review is very much on learning and improvement. The review period covers the period from March 2021 (Rapid Review Panel Date) to May 2022.

This review has been conducted in conjunction with a multi-agency audit, which involved seven cases of infants and young children who presented with signs of neglect to highlight any further systemic learning. The cases were submitted by the Children’s Social Care, Metropolitan Police, Barts Health, GP Care Group and Named GP.

The methodology for the review itself included:

* **A large-scale, system wide workshop**, chaired by Geraldine O’Donnell in which all professionals involved in the case were invited to attend and review the case from each perspective and review the systems used within the case.
* **A children’s services focused workshop** chaired by Geraldine O’Donnell to review systems.
* **A series of individual interviews** conducted with each professional involved in the case and/or the management of the agency.
* **A multi- agency audit** was conducted into seven cases regarding Infant Neglect this activity was chaired by Keith Makin, Independent Scrutineer.
* Tower Hamlets Children’s Social Care also facilitated an **interview with Julie’s Mother** to secure her contributions, contact was attempted with Julie’s father but he was unable to engage.
* **Local and national research** on key areas identified.
* During this report period a second infant with a head injury came to the attention of the THSCP, a review workshop was held and the learning is woven through this report, the infant’s name is changed in this report to ‘Daniel’.

The final report has been authored by Geraldine O Doannell and Louise Griffiths who are employed by the London Borough of Tower Hamlets. Geraldine is responsible for Quality and Assurance; Louise Griffiths manages the Safeguarding Children Partnership and both authors do not have direct contact or management of the cases within this review. Victoria Burton who is the Co-ordinator for the Safeguarding Children Partnership supported with co-ordination of the review and national research.

The Independent Scrutineer was present at all workshops and audit activity. Significant and considered contributions were provided across the partnership. The review group was made up of senior managers from all agencies involved with Julie and her family in recent months.

The agencies involved in the review, including the multi-agency audit, were:

* Barts Health NHS Trust– Safeguarding Team
* Barts Health - Doctors involved
* Children’s Centre Representative
* Clinical Commissioning Group
* Tower Hamlets GP Care Group – Health Visiting Services
* London Borough of Tower Hamlets – Commissioning
* London Borough of Tower Hamlets - Adult Services
* London Borough of Tower Hamlets - Assessment & Intervention & MASH
* London Borough of Tower Hamlets - Children’s Social Care
* London Borough of Tower Hamlets - Early Help Services
* London Borough of Tower Hamlets - Education Safeguarding Team
* London Borough of Tower Hamlets - Public Health
* Metropolitan Police – CAIT
* Metropolitan Police – Safeguarding Team
* Metropolitan Police – Specialist Crime
* Named GP for Safeguarding
* North East London Foundation Trust
* THSCP Business Unit (Business support role)
* THSCP Independent Scrutineer (Audit Chair, observer, and critical friend role)
* Voluntary Sector Representative

# **Summary Findings, Themes Relating to:**

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| **Theme 1**  | Appropriate sleeping arrangements of the baby, infant supervision, and appropriate accommodation.  |
| **Theme 2**  | Identifying and addressing infant neglect  |
| **Theme 3** | Thresholds, decision making meetings and record keeping  |
| **Theme 4** | Impact of covid 19, including the impact of delivering face to face services and the effect that has had on families. |
| **Theme 5** | Consistent use of Interpreters and Advocates  |
| **Theme 6** | Assessment of vulnerabilities in mothers including potential exploitation |
| **Theme 7** | Domestic abuse (DA), the use of DASH and awareness of historical DA within agencies.  |

# **Theme One**

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| **Theme 1**  | Appropriate sleeping arrangements and accommodation of the baby and infant supervision |

**How was this issue relevant to this case?**

Both head injuries were caused by lack of supervision on an unsuitable surface. Prior to Julie’s birth little preparation had been made for her arrival, there were no raised or noted concerns about Julie going home following her birth. Post birth, the first home visit was undertaken by the midwifery team. Julie’s sleeping arrangements were reported to be inappropriate. Due to a criminal investigation mother did not have access to any funds. The Local Authority provided funds for appropriate sleeping equipment, which was not released until weeks after. Checks by the Social Worker or the Health Visitor were carried out one month after funding was provided to ensure that Julie had an appropriate place to sleep. It was noted that a pram was available, but this is not where the baby was sleeping and there were missed opportunities for professional curiosity to enquire. The financial provision for a Moses basket did not make a significant difference to the baby’s sleeping arrangements, and a timelier follow up from professionals was required.

The child’s initial injury was caused by falling off a bed onto a hard surface. Mother first sought medical attention for Julie five days after the injury when she took Julie to the Emergency Department. Earlier that day, Julie and her mother attended a Child Health Clinic during which Julie was reviewed by a Health Visitor. Julie’s mother did not report the injury and it was not identified by the Health Visitor. When Julie was admitted to hospital for the first head injury hospital staff raised various concerns including prop-feeding, co-sleeping and leaving baby unattended which was communicated with children’s social care. Checks were carried out and there were no other physical concerns. Post discharge good level of contact took place and professionals reported that Julie had appropriate areas to sleep and play. Approximately four weeks later, mother attended a routine appointment at the hospital where a second head injury from the same cause was found.

**Does this happen in other cases?**

Co-sleeping is very common in many cultures and can be seen as a natural part of the child-rearing process. It is considered a cultural value system emphasizing family bonds and interpersonal interdependence which seem to act as positive reinforcing factors for this practice.

Three out of the seven cases within the infant neglect audit for this CSPR identified issues with accommodation, although there were no concerns around sleeping arrangements, the concerns were regarding housing and appropriate accommodation. An audit case categorised under neglect demonstrated that the primary issue was overcrowding, within another audit case a hotel room was used as a housing solution to a mother who had been trafficked and her infant. Questions were raised whether these cases were neglect or poverty and the limited access to suitable housing.

The baby Daniel workshop identified that mother had engaged well with services ahead of the injury and that home safety and sleeping arrangements were both discussed with her. It was noted that mother is a single carer and the health visitor did not recall discussing how to keep baby Daniel safe while she showers or uses the toilet. It is noted that following the review, the GP Care Group Health Visiting Service, reviewed their Standard Operating Procedures and record keeping templates to ensure all relevant aspects of home safety is included within core contacts. This case also demonstrated a mother living in a hotel room, which impacted not only availability of equipment and space, but also increased her social isolation. Daniel’s cot was not detailed in the case notes, it was unclear if this was a travel cot or permanent cot. It would be useful for professional to explicitly record the detail of sleeping arrangements.

A National Review of Non-Accidental Injury in under 1s, made evident that when safer sleeping advice is given, it can be overwhelming for carers when presented as a list. ‘Models of intervention that rely ‘solely on giving information are unlikely to produce meaningful change and it is noted that there is ‘a need for a flexible and tailored approach to prevention which recognises and is responsive to the reality of people’s lives’. The best approach was seen when advice is embedded into the usual service provision.

**Why does it matter?**

Safe sleeping arrangements can reduce the risk of injury or death in infants. Bed-sharing (the baby sleeping in the parental bed with one or both parents) is an ancient, and still common, worldwide cultural practice. Although there is an association between bed-sharing and Sudden Infant Death Syndrome, (SIDS) increasingly the evidence suggests that it is not bed-sharing per se that is a risk factor, but the circumstances in which it occurs. The 2014 NICE review of co-sleeping and SIDS concluded that it is not possible to say that 'co-sleeping causes SIDS' and so parents should be advised there is an 'association' rather than a 'risk'..[[2]](#footnote-2)

**Recommendations for the Tower Hamlets Safeguarding Children’s Partnership:**

* Promote learning as a public health message about the importance of avoiding co-sleeping and unsafe sleeping arrangements. Black Country CDOP have a [7 minute briefing](https://go.walsall.gov.uk/Portals/37/2021_01_21%20-%207%20MINUTE%20BRIEFINGV4%20edit.pdf) on Safe Sleeping and Lancashire SCP demonstrate [a wide range of tools](https://www.lancashiresafeguarding.org.uk/child-death-overview-panel/safer-sleep-guidance-and-materials.aspx).
* Online pre-birth packs are available in Tower Hamlets however these are not available in different languages and only digital versions exist, explore if translated versions can be made available.
* The THSCP to review:
	+ What is the multi-agency protocol for ensuring that parents have made sufficient preparation for arrival of baby?
	+ How does the THSCP ensure practitioners understand parenting approaches in different cultures?
	+ What protocols are in place for when inappropriate housing becomes a safeguarding risk and ensuring this is not falling unnecessarily under the category of Neglect?
* The Scottish Government provides baby boxes for every new born baby which ensures a safe place to sleep[[3]](#footnote-3), explore what provision Tower Hamlets could provide on a needs basis.

**Theme Two**

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| **Theme 2**  | Identifying and Addressing Infant Neglect  |

During this case, Neglect was identified as the underlining cause of the infant’s head injury. Julie attended a Child Health Clinic post the injury, however, it was not identified by the health visitor who saw her that Julie had a head injury at this time. Mother had waited five days before seeking medical advice from a pharmacist who told her to go to A&E. The medical staff agreed the injury was consistent with the account that she gave. The LBTH Neglect Tool Kit was used by Children’s Services prior to the first head injury, but the tool kit was never revisited and was only carried out by one agency. It was seen as a ‘one off exercise’ rather than an ongoing live piece of work.

**Does this happen in other cases?**

Within the multi-agency audit into Infant Neglect, it was identified that the neglect tool was not used or used by a single agency and not shared. It was noted by all professionals in attendance that the voice of the infant was not captured within the cases. It was acknowledged that the voice of the pre-verbal infant is difficult to collect. A key overall theme emerged from the audit was non-engagement of parents within the Child in Need process. Cases were closed due to non-engagement, rather than the non-engagement seen as a reason to review how trust might be built and the parents might be effectively engaged. Other neglect indicators such as children not registered with GPs were also raised in the audit.

**Why does it matter?**

Neglect is a difficult area to identify, and indicators such as non-engagement and children not being registered with health services are important to pick up alongside the more ‘obvious’ signs of neglect. If these indicators are not identified, the risk of harm may increase to the child.Professional Curiosity is key to understanding all the elements within family and therefore understand any risk to a child.

**Recommendations for the Tower Hamlets Safeguarding Children’s Partnership:**

* Neglect took kit to be promoted within Multi Agency forums and used as a tool where all agencies involved contribute.
* To review practices to capture the voice of the infant.
* Pan London Procedures have information on hard engage families, this should be recirculated and embedded into practice.
* Support for practitioners regarding Professional Curiosity, such as tool kit, bitesize videos or training.

# **Theme Three**

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| **Theme 3** | Thresholds, decision making meetings and record keeping |

**How is this relevant to this case?**

The process of making decisions was not always clear to all professionals involved. It was noted the Child in Need Meeting was difficult for the parent who did not speak fluent English. Mother has given feedback during the CSPR process that the number of professionals involved added stress on to her marriage.

The hospital kept in continuous communication with the Children’s Services Team during both incidents. Throughout the case, there was a turnover of health visitors and some confusion over a strategy meeting. At point of discharge, professionals in health reported attending a Strategy Meeting but were then later advised it was a Discharge Planning Meeting and the Strategy Meeting had already been held. The strategy meeting was held when the child was on the ward, the health visitor was present but the current health staff such as the paediatric consultant or nursing staff were not invited. Strategy meetings should have a membership of all professionals currently involved with the child. This is key to the case as the hospital staff had picked up on unsafe behaviours demonstrated by mother in respect of safe sleeping and feeding.

Over the period of two days, when the key meetings took place a total of three health visitors were involved at separate times which is a significant changeover of health visitors during the decision-making period.

During the handover process between the midwife and health visitor, the Health Visitor was not initially informed that the child was known to Children’s Service, and only gained this information when GP files were checked. Within the health service mother’s antenatal notes wouldn’t have been transferred to baby’s notes which missed out key information about the child and risk. The health service reported that this can be difficult due to the different record keeping systems and unclear handover and information-sharing processes.

Julie’s mother was referred to Children’s Social Care prior to Julie’s birth at a time when she was arrested and pregnant. The reason for arrest was sufficient for Children’s Social Care to consider whether Section 47 inquiries should have been undertaken at that time, but instead an assessment was undertaken, and Julie was deemed a child in need (CIN) and a CIN plan devised.

**Does this happen in other cases?**

Within the multi-agency audit into Infant Neglect, the findings indicate that cases were closed due to parental non engagement. Within Audit case two, the step-down process was queried. There was a concern of Child Protection, but the case was stepped down due to non-engagement and the case was not re-escalated. The case went from a Child Protection conference to universal support services within one week. Audit case five showed that no referrals were made to Early Help when the case was closed to Children’s Social Care, as the parent did not consent to other interventions. The parents did not attend the Team around the Family meeting; therefore, it was difficult to see how a decision could be made without their involvement.

Regarding decision making meetings, an audit case detailed children who were deregistered from GPs, but the GPs were not invited to the Child in Need meeting, so this information was not shared. In cases with high levels of deprivation and vulnerable families, it is a risk that communication between Health Visitors and GPs has decreased.

The case of baby Daniel identified differing levels of information sharing between agencies. While Child Protection meeting minutes are routinely shared by Children’s Social Care, Child in Need and Strategy Meeting are not always shared with agencies for information. Professionals at the workshop explained the GPs often send children to the Emergency Department but do not refer into MASH as they expect that this will take place at the Emergency Department.

**Why does it matter?**

The right people at the right time are essential to ensure all facts are known about a child when making a Threshold Decision. Record keeping and information sharing is critical to ensure that professionals have the correct information to safeguard a child.

**Recommendations for the Tower Hamlets Safeguarding Children’s Partnership:**

* Review how to support practitioners around the non-engagement of parents and carers to ensure cases are appropriately stepped down.
* Comms to be sent out to all staff around the expectations of Strategy Meetings, primarily who needs to be in attendance.
* It is noted that the GP Care Group Clinical Director for 0-19 Services , is meeting with the Named GPs to discuss solutions regarding information sharing. GP Care Group are additionally reviewing how to strengthen continuity of care when vulnerable families move to other parts of the borough. The THSCP to follow up.
* Report to be run to see how many Child in Need Children are without a GP record.
* To review if GP deregistration should be discussed at a Multi- Disciplinary Team Meeting for vulnerable families.
* Review what percentage of MASH referrals are received from GPs and if this is low, is awareness raising on thresholds/referral processes needed for GPs?

**Theme Four**

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| **Theme 4** | Impact of covid 19, including the impact of delivering face to face services and the effect that has had on families. |

The case was known to agencies through the Covid-19 pandemic when lockdowns were instructed nationally. Prior to birth a face-to-face home visit was carried out by the midwifery team, the midwife had raised concerns to Children’s Social Care at this point due to a lack of preparation for baby’s arrival. Most of the contact between the Health Visitor and Mother /baby post birth was carried out virtually, baby was seen first time by a health visitor at five months old in a clinic setting. Five contacts with the health visitor were carried out virtually four out of the five sessions used a camera video call function, and one was a phone call. The virtual sessions continued until the end of August 2020. In June 2020, National Guidance was released explaining that Health Visiting should resume to face to face contacts however, face-to-face contacts visits did not resume within this case. The PHE guidance and local restoration plan states that health visiting should “Fully restore service, with some prioritisation where indicated and as capacity dictates" and "Face-to-face contacts should be prioritised for families who are not known to services to mitigate known limitations of virtual contacts and support effective assessment of needs/ risks."[[4]](#footnote-4) The allocated Health Visitor was not undertaking face to face contacts due to Covid 19 and a colleague who would be able to undertake these as per the local Covid risk assessment, was not successfully identified.

When baby was first seen face to face by health visitor in the clinic when 5 months old, the baby had already incurred the head injury. The injury was not identified by the Health Visitor during the contact. Mother did not mention the injury to health visitor at this time. Later that day, the mother took Julie to a pharmacy to address the head injury and subsequently, the infant was admitted to hospital with a skull fracture. The injury was described by medical staff as ‘large’ and ‘boggy’. A review was undertaken by GP Care Group at the time of this incident to understand why the injury was not identified by the health visitor. Following discussions with the Consultant Paediatrician who reviewed Julie in the Emergency Department when she attended, it was concluded that the injury may not have been easily visible to the health visitor at that time.

Covid-19 restrictions were in place meant some services had to reduce face to face visits and public facing services. Health visitors were encouraged to ask explicitly to see sleeping arrangements, but this is not always possible via video calls. It is acknowledged that Children’s Social Care continued face to face visits.

**Does this happen in other cases?**

Within the Infant Neglect audit a common theme emerged that Covid 19 negatively affected the engagement with families, specifically the closure of children and families’ centres and there was limited available activities offered due to services being closed.

It is important to note that community support outside of services had largely ceased due to the lockdowns, so parents and families were cut off from external assistance and contact.

**Why does it matter?**

The Petitions Committee has launched its report, Impact of covid-19 on new parents: one year on, which calls on the Government to publish a dedicated covid-19 recovery strategy for new parents[[5]](#footnote-5).

Since last July, new and expectant parents have continued to face severe limits on the formal and informal support for their wellbeing and their child’s development that they would normally expect. The inquiry last year heard compelling evidence on the crucial role of community support and parent and baby groups in supporting new parents’ wellbeing.

Virtual checks were a necessary innovation during covid-19, but new parents and their children must now urgently receive in-person visits—ideally from a health visitor, but, if this is not possible and in view of the time-sensitive nature of this need, then from another qualified professional.

**Recommendations for the Tower Hamlets Safeguarding Children Partnership**

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| * Assurance that face-to-face practice has fully returned within health and social care.
* Continue to review the effect of the pandemic on multi-agency practice and families.
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**Theme Five**

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| **Theme 5** | Consistent use of interpreters and advocates  |

**How was this issue relevant to this case?**

Julies mother’s first language is not English and the review it showed an inconsistent use of interpreters. Some records state that mother needed an interpreter and that she understood some English. The depth of her understanding of English was never determined. Discussions took place with mother following Julie’s birth about sleep management, home safety, minor illnesses, immunisations, and the Care Confident Programme (educational resource aimed at supporting families with under five-year-olds) but none of these took place with an interpreter.

During four out of the five sessions virtual sessions conducted by the Health Visitor, no interpreter was present. During the first admissions into hospital, no interpreter was provided for mother on the ward so it was unclear if she understood all the advice given to her. Nurses advised mother around safe sleeping although she continued to put baby in her own bed at night. They also spoke to mother as she was also going to use an unsterilised bottle, but an interpreter was not used. During the second admission to hospital interpreters were consistently used.

GP Care Group had a mechanism for recording a family’s need for an interpreter but 0-19 staff are unaware of the functionality in the electronic recording system. The police consistently used in interviews with Julies Mother. During a Domestic Abuse Stalking and Honour-based (DASH) assessment there was an Independent Domestic Violence Advisor (IDVA) but no interpreter present. All agency records were also lacking information on cultural background, this information could have supported practitioners to gain further understanding into cultural practices regarding sleeping arrangements.

**Does this happen in other cases?**

Within the National Review of Non-Accidental Injury under 1s, “the impact of ethnicity and culture on parenting was not overtly considered or evidenced in many of the cases and in some there was no reference to cultural background in case documentation. The overriding impression was that practitioners need more confidence to acknowledge and explore the impact of ethnicity and culture on parenting and that this needs to become an expected aspect of practice in all cases…An aspect of practice where there was a more explicit consideration of ethnicity was in the use of interpreters. In some areas interpreting services might not be easily available and practitioners expressed concern about the impact on assessments where family members were used to interpret”.[[6]](#footnote-6)

The case of Daniel demonstrated good practice of interpretation, at all levels and mother had an advocate from a national charity supporting her.

**Why does it matter?**

Untrained interpreters are more likely to make errors, violate confidentiality, and increase the risk of poor outcomes. The use of professional interpreters (in person or via telephone) increases patient satisfaction, improves adherence and outcomes, and reduces adverse events, thus limiting malpractice risk.

**Recommendations for the Tower Hamlets Safeguarding Children’s Partnership:**

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| * Investigate how agencies ensure interpretation services are used, and how is the level of need of interpretation is addressed and recorded and ensure the interpretation services are easily accessed by practitioners.
* Communications/ awareness raising to be sent out to practitioners on consistent use of interpretation and cultural competence.
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# **Theme Six**

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| **Theme 6** | Assessment of vulnerabilities in parents including potential exploitation  |

**How was this issue relevant to this case?**

Throughout this case the full vulnerabilities of the mother have never been fully established. The father was known to the police for criminal activity including exploitation and domestic abuse. Julie’s mother was known to the police for regarding involvement in organisation crime. During the policing process Julies mother was seen as primarily being seen as ‘the risk’ as opposed to being ‘at risk’. When Julies Mother was arrested, she was held overnight at eight months pregnant and questioned in the morning. Julie’s mother was asked once if she had been forced or exploited into the crime, but there was not any further exploration. The criminal investigation appears to have sat aside from any of the assessment undertaken, at this point there were no safeguarding concerns noted. Harm outside of the home was not considered in assessments. Whilst the Julie’s Mother was on the hospital ward concerns around a visitor arose, but this information had not been passed on which could have helped parallel investigations.

Mother was known to be under criminal investigation prior to the child being born, the case was under standard midwifery services rather than the gateway midwifery service (a specialist team who work with mothers to be who are vulnerable).

**Does this happen in other cases?**

All seven audit cases showed vulnerabilities within mothers which includes, trafficking, exploitation, domestic abuse, physical health conditions, mental health concerns and learning needs/ disabilities. These vulnerabilities add a level of complexity to the cases and should mean support is adjusted to each family’s needs. Within all audit cases and Julie’s case, there was limited about information fathers and their role within the families.

Within the case of baby Daniel, the mother had been trafficked into the country and like Julie’s mother was visited in hospital by an unknown male which was not challenged by staff. Daniel’s mother has mental health difficulties relating to her trauma.

Swindon LSCP undertook a thematic review on infants with head injuries, they have now implemented a monthly meeting between Named Midwife in GWH, the FNP Supervisor and the Named Nurse for Safeguarding in Swindon Community Health in order to share information and monitor pregnant woman where there are known vulnerabilities and safeguarding risks. [[7]](#footnote-7)

**Why does it matter?**

When the vulnerabilities of care providers are overlooked, it can cause further distress on the family. Without a ‘Think Family/Community’ approach it can mean that there is not a full understanding of a case. Think Family means securing better outcomes for adults, children, and families by coordinating the support and delivery of services from all organisations. When an individual first has contact with any service they should receive a welcome into a system of joined-up support and safeguarding together with coordination between adult and children's services. Families do not exist in insolation and are often complex so think family also may mean ‘Think Community’.

A national review named ‘The Myth of invisible Men’[[8]](#footnote-8) showed there was evidence that fathers were not involved in care planning from midwifery to family court and stated “The opportunity for offering support to men who might need it in their role as fathers, for early identification of both parental and children’s vulnerabilities, and potential risks that these indicate, are not maximised.”

**Questions for the Tower Hamlets Safeguarding Children’s Partnership:**

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| * Ensure there is a multi-agency agreement and approach to a Think Family/ Think Community strategy, and this is replicated in practice.
* Ensure there is a Trauma Informed Model of support across all safeguarding agencies in Tower Hamlets.
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# **Theme Seven**

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| **Theme 7** | Domestic abuse (DA), the use of DASH and awareness of historical DA within agencies.  |

**How was this issue relevant to this case?**

Julie’s father has convictions of domestic abuse regarding his previous relationship and there was also a domestic altercation between Julie’s parents which resulted in police involvement. It was also noted that Julie was present during an altercation. A domestic abuse, stalking and 'honour'-based violence assessment also known as “DASH” was carried out, but this was used as a referral mechanism rather than a tool itself. DASH was carried out with an IVDA (advocate) but not an interpreter. The father was challenged through the social work general assessment process but did not want revisit the incidents. The social worker allocated after Julie’s second head injury was not aware of the historical DA in the family, the police and social work colleagues were the only agencies who had knowledge of the DA. It is noted the parents separated prior to Julie’s injuries.

**Does this happen in other cases?**

In the year ending March 2020, an estimated 2.3 million adults aged 16 to 74 years experienced domestic abuse in the last year (1.6 million women and 757,000 men).[[9]](#footnote-9) Three cases out of the seven audited cases showed a history of Domestic Abuse. Specifically in case seven the category of Neglect was used due to the presence of Domestic Violence and Abuse, the children in the family saw this as common place. It is noted that the father is completing a positive change programme and taking on board the learning, therefore the case was stepped down from Child Protection to Child in Need. Managers involved in this audit, asked ‘is it right that if children who are exposed to Domestic Violence and Abuse should be categorised under Neglect?’.

A national statutory definition of domestic abuse is soon to be brought into force, “Part 1 of the Act provides that a child who sees or hears, or experiences the effects of, domestic abuse and is related to or under parental responsibility of the person being abused or the perpetrator is also to be regarded as a victim of domestic abuse. This means that where the Act imposes a duty in relation to victims of domestic abuse, this will include children as described in Part 1.”[[10]](#footnote-10)

Hackney CSP published a CSPR in 2021, where Child R was seriously injured by mother’s partner. There was a history of DA and mother with other vulnerabilities retracting allegations of DA. Mother made the following comments aimed at practitioners working with victims of domestic abuse: “*It might not be a big hint but look at facial expressions. Just because I am smiling it doesn’t mean everything is ok. Give them (the victim) the chance to have the courage to speak up about what is happening to them, listen to them.” “Not all victims have the courage to speak behind their partner’s back.” “I wish I had been more persistent, and they might have listened to me - I would be now”[[11]](#footnote-11)*

**Why does it matter?**

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| **Recommendations for the Tower Hamlets Safeguarding Children’s Partnership:*** Explore with practitioners how can a DASH assessment be utilised on a multi-agency level and as more than a referral tool.
* Ensure information sharing is consistent within and throughout agencies.
* Explore the use of the category of ‘Neglect’ for children and young people who bare witness to Domestic Violence and Abuse in the home, review if a new category can be introduced so it is clear to all those involved that DVA is the main reason for safeguarding intervention.
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# **Closing Statement**

All professionals involved in this review held open, honest, and difficult conversations. The hard work and willingness to improve practice in Tower Hamlets is acknowledged. Gratitude also goes out to Julie’s family who supported this report. Whilst this review was ongoing professionals had started making changes to how sleeping arrangements are recorded. The actions from this review are agreed by all partners and will be carried out by a multi-agency working group. The Tower Hamlets Safeguarding Children Partnership have made a commitment to focus on infant safety over the coming months.

1. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\_data/file/942454/Working\_together\_to\_safeguard\_children\_inter\_agency\_guidance.pdf [↑](#footnote-ref-1)
2. <https://www.unicef.org.uk/babyfriendly/wp-content/uploads/sites/2/2011/11/Caring-for-your-Baby-at-Night-A-Health-Professionals-Guide.pdf> [↑](#footnote-ref-2)
3. <https://www.nhsinform.scot/ready-steady-baby/pregnancy/preparing-for-parenthood/baby-box> [↑](#footnote-ref-3)
4. <https://www.england.nhs.uk/coronavirus/documents/c0552-restoration-of-community-health-services-guidance-cyp-with-note-31-july/#Covid_restoration> [↑](#footnote-ref-4)
5. https://committees.parliament.uk/committee/326/petitions-committee/news/161509/governments-response-to-impact-of-covid19-on-new-parents-report-demonstrates-a-continued-lack-of-action-say-mps/ [↑](#footnote-ref-5)
6. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\_data/file/1017227/National\_Review\_of\_Non-Accidental\_Injury\_in\_under\_1s.pdf [↑](#footnote-ref-6)
7. <https://safeguardingpartnership.swindon.gov.uk/downloads/file/1032/lcspr_babies_with_injuries_report> [↑](#footnote-ref-7)
8. <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1017944/The_myth_of_invisible_men_safeguarding_children_under_1_from_non-accidental_injury_caused_by_male_carers.pdf> [↑](#footnote-ref-8)
9. <https://www.gov.uk/government/publications/domestic-abuse-bill-2020-factsheets/statutory-definition-of-domestic-abuse-factsheet> [↑](#footnote-ref-9)
10. <https://www.gov.uk/government/publications/domestic-abuse-bill-2020-factsheets/statutory-definition-of-domestic-abuse-factsheet> [↑](#footnote-ref-10)
11. <https://chscp.org.uk/wp-content/uploads/2021/12/PUBLISHED-CHSCP-Review-Child-R-Report-FINAL.pdf> [↑](#footnote-ref-11)