Thematic Review - case reviews 2019

This report considers the themes and learning from ten case reviews. 3 partnership reviews, 2 DHRs/SCRs and 5 serious case reviews – the scope of reviews covers a significant period from 2007– 2017/8.

1. Key themes

1.1 **Professional Curiosity.** In all cases there was a degree to which risk was left unchallenged through lack of professional curiosity, acting as an inhibitor to understanding the full extent of risk faced by the child(ren). The reasons for this were varied but can be summarised as:

- Lack of capacity in Health Visiting service
- Lack of managerial supervision and reflective practice
- Assumptions about the narrative given by the parents with lack of **respectful challenge**
- Responding to coercive and aggressive behaviours
- Cultural bias

The impact of practitioners not consistently being curious and challenging narratives was that at times indicators of abuse, particularly neglect and domestic abuse were not recognised, recorded or escalated. There were missed opportunities to safeguard and involve other services which could have provided a more holistic overview of the child(ren) history.

In relation to neglect, there was a lack of challenge and curiosity of parental narratives and or with domestic abuse and neglect lack of curiosity in relation to coercion and control where interventions particularly from health and mental health focused on physical presentations rather than emotional health and wellbeing. Professionals seemed to become habituated to presentations of neglect.

1.2 Domestic abuse/Coercion and control

Seven reviews spoke of domestic violence and coercion and control. This manifested as increasing push back on services, obstruction and or refusal to allow services in. In some cases this enabled the aggressive parent to move the focus onto them and away from the child – it also had an effect on practitioners' ability to challenge and steer the conversation to professional concerns as managing parental behaviours.

Common to all the observations of coercion and control was the challenge of evidencing significant harm or abuse. It was often observed and considered but there wasn't clear action in response. As a mirror to the aggression of coercion and control there were cases of **disguised compliance** in either case it served to deflect practitioners' attention from deeper investigations.

A theme running through some of these cases where domestic abuse, particularly coercion and control was the impact on the emotional and mental wellbeing of the spouse – two cases identified incidents of physical assault on the child by the mother that may have been seen as an indicator of domestic abuse. There were cases whether mother was charged and the father retained parenting capacity –where supervision orders were put in place there was a knock on impact leading to supervision as a point of control for the coercive spouse. In these cases there was insufficient attention given to the concerns of the mother over the behaviours of the father which if investigated further potentially could have resulted in referral to MARAC. There was also evidence of lack of understanding of how coercion can lead to retaliate to violence. There was some learning suggesting that there were failures to link parental mental health issues with domestic violence and child(rens) presentations to health as linked to physical violence/neglect. A situation exacerbated by note having access to family histories.

The reviews also highlight the ongoing impact on the emotional and mental wellbeing of children who are subject to or witness domestic abuse, domestic abuse in the context of the reviews considered also highlights the issue of **'grooming'** of both professionals and other family members including the children. Of then ten reviews grooming of professionals and children to support the preferred narrative was explicit in three reviews.

1.3 **Multiple referrals and re-referrals.** The reviews give a significant amount of learning on **referrals.** One of the most common themes emerging was multiple and repeat referrals to either to children social services, or CAMHS NFA'd as not meeting the threshold**,** with referrals coming from more than one agency. Overall, there is a general feeling that this was more prevalent in cases of neglect and domestic violence.

The impact of a child not meeting thresholds for targeted or specialist support early in the life of the child meant that opportunities were missed to safeguard the child or put in support and services to reduce the risk of harm or abuse. A common thread was the ongoing concern of other professionals.

Conversely, there were missed opportunities to refer where a child would have met the threshold that were not taken – this appears to be mainly in response to personal disclosures either by adult or child that would have warranted further investigation, such as disclosure of physical violence.

1.4 Assessments and Planning – right support right time; common themes identified across the reviews include:

- Premature **or poor planning and risk management in step down arrangements** across services
- Poor communication
- Drift and delay in the completion of assessments
- Poor quality assessments including lack of clear outcomes and poor decision making
- Not sharing assessment outcomes with key partners
- Missing critical input from key partners in planning meetings
- Lack of clear risk rating and risk mangagement around assessments
- Poor follow up of assessments
- Asesssment being made without face to face conact
- Over-optimistic assessments

- Assessments tooo heavily reliant on parental narrative
- Poor communication of assessments.
- Lack of child and family history

1.5 **Escalation on professional dissent:** Among health and universal services there was some evidence of child protection procedures not being fully followed. This included missed opportunities to refer to child social services, or escalate to the paediatrician in hospital. More commonly was the **lack of understanding of resolution procedures** for dissent in decision making over the risk of harm to a child. There are clear policies for escalating a concern over the professional judgement of risk to a child from another agency – but these seem not to be well understood or followed in at least three cases. In one case there was evidence of over reliance on expert opinion rather than on professionals with longer term contact with the family. In Child Protection conferences there was evidence that professional opinion was not equally weighted.

1.6 **Developmental Milestones,** particularly in neglect cases failure to meet milestones can be a significant indicator of abuse. Common to these cases were **home observations.** Some agencies demonstrated greater awareness of home conditions on the emotional and physical wellbeing of the child than others. In common was the challenges in understanding the impact of cumulative neglect before coming to crisis point. Learning from the reviews highlights the need to understand neglect in the context of historical concern and multi-agency interactions – without a holistic view of the risk supported by good information sharing neglect can be hard to identify. The neglect cases reviewed all reflected the uncertainty of whether there was neglect or health presentations where each incident was seen and treated in isolation. Of the cases neglect cases reviewed, the authors frequently mentioned delay development as an indicator of abuse.

1.7 **Parental Capacity** across the reviews there were a number of opportunities to reflect on parental capacity and the impact of various parental vulnerabilities from mental health, physical health, and substance misuse to learning difficulties.

There were opportunities to listen to professionals with concerns and longer term contact with the families that would have in a broader context led to a more robust assessment of need and risk. There were alsp opportuhnities to listen to disclosures of one spouse on the other.

Parental capacity was not always considered due to underlying assumptions on the quality of parenthood based on unchallenged narratives of events or single presentations. This allowed for the explanation of events to be directed by the parent/carer.

In all of the neglect and domestic abuse cases considered one or both parents were invovled in the abuse of the child. In the context of the child sexual exploition cases this vulnerability was not known to be an occurrence in the family home, but an external community or social risk. Although the CSE cases have some commonality with the themes of the neglect and domestic abuse cases, in the small number reviewed there seems to have been extensive interventions across agencies, often joined up albeit with different applications and assessments of risk. The challenges in these cases appear on the surface to be more around the **efficacy of strategies** put in place to manage the risk and the lack of specialist resource accessible both in and out of county. Multiple placements appear to have an ongoing impact on stability for both the child, their personal relationships and education. Movement in placements were often

sited in the two reviews as due to the inability or suitability of placement to manage behaviours – behaviours which were oversexualised, self harming or otherwise risky were little understood and required expert assessment to disagnose.

In common with all cases a subtext to the reviews is the impact of abuse and neglect both current and historical to the parent, on the ongoing emotional and mental health of the family. In the two CSE cases there was little evidence that the impact of early trauma on behaviour was understood. In the neglect and domestic violence cases there was evidence that violence in the family had been a factor both historical and present.

1.8 **Lived experience of the child** was another common element of all the reviews, and most clearly captured by the consultation with children and young people during the review process, and their families. Each case identified a missed opportunity to understand the experience of the child(ren) from either there own or a siblings perspective. In some cases this resulted in actions taken in the best interests of the child that did not fully consider the potential and actual trauma that these actions caused, in other cases it lead to delay in understanding the abuse or negect experienced by the child(ren). In some cases this led to disclosures by the child to professionals not prompting referral or other approriate actions.