Local Child Safeguarding Practice Review

Child R

December 2021

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1. Introduction

1.1 On arrival at the family's address, paramedics from the London Ambulance Service (LAS) found Child R to be unconscious with extensive physical injuries. He had bruising, lacerations, scabbing to his cheek, a large cut on his back and scarring around the feet. The accommodation was unkempt and there were signs of disturbance. Paramedics contacted the Metropolitan Police Service (MPS). Child R was taken to hospital, where further tests identified a bleed on his brain.

1.2 No explanation was given to the police to account for Child R's condition or his injuries. Child R's mother maintained she had not seen anything and that her son was with her partner (*Partner 4*) prior to the ambulance being called. A witness reported hearing shouting and sounds of a child being hit.

1.3 Child R and his mother had only recently moved to Hackney and were living in temporary accommodation. Risks relating to domestic abuse and concerns about mother's parenting capacity were evident in the family history. In the days immediately preceding the discovery of Child R's injuries, reports were made to the police about his safety.

1.4 Following a criminal investigation, Partner 4 pleaded guilty to Grievous Bodily Harm and to causing or allowing a child to suffer serious physical harm. He was sentenced to three years imprisonment. Child R's mother pleaded guilty to causing or allowing a child to suffer serious physical harm. She was sentenced to two years imprisonment, suspended for two years, and with requirements for unpaid work, rehabilitation, and community service.

1.5 Notwithstanding the impact of the emotional trauma experienced by Child R, he has physically recovered from his injuries.

1.6 Given the circumstances of this case, a Local Child Safeguarding Practice Review (*the review*) was initiated by the City and Hackney Safeguarding Children Partnership (CHSCP). The review focused on four questions:

- *What was the sufficiency of the transfer process when Child R moved into Hackney?*
- *How effective were individual agencies and the multi-agency partnership in identifying potential risk and protecting Child R from harm?*
- *Did the Covid-19 lockdown arrangements have any bearing on individual or multi-agency practice in Hackney and / or the serious harm inflicted upon Child R?*
- *Did any other practice issues, either single or multi-agency, have any bearing on the serious harm inflicted upon Child R?*

1.7 The review makes six findings and seven recommendations for improving practice.

2. Key Circumstances, Background and Context

2.1 Child R was born in late 2017. He is of mixed White and Black Caribbean heritage and initially lived with his mother and members of his extended family in Lambeth.

2.2 Child R's mother was 18 years old when she gave birth to her son. As a child, she received support from Lambeth Council as part of a 'child in need' plan. There was a noted family history of attention deficit hyperactive disorder, parental mental health issues and learning difficulties. Child R's mother also reported being physically abused by another family member.

2.3 Child R's biological father (*Partner 1*) played no measurable role in his life. Mother's subsequent partners, however, were all significant in the context of the risks that both surrounded and impacted upon Child R. These adult males had a history of criminality that involved supplying drugs, threatening behaviour, burglary, conspiracy to rob and domestic abuse.

2.4 When Child R was a few months old, his mother asked Lambeth Council for help in finding alternative accommodation (as she wasn't getting on with her

family). This was arranged and in early 2018, mother and Child R went to live in a hostel for young mothers[1]. Whilst here, she was assaulted by an ex-partner (*Partner 2*).

2.5 A few months later, Lambeth Council supported Child R's mother to move again, this time into private accommodation in Croydon. Whilst initially confident, Child R's mother began to struggle, and the local health visitor made a referral for early help support. This referral was either not received or not acted upon by Croydon Council[2].

2.6 Three months later, the health visitor made a further referral highlighting that mother was socially isolated and that this was impacting upon her parenting. The referral also described mother's epilepsy, obsessive compulsive disorder, anxiety and noted issues with anger.

2.7 An early help practitioner was allocated to work with Child R and his mother in mid-August 2019. Over the next few months, Child R's lived experience was characterised by a growing level of dysfunction at home.

- An ex-partner *(Partner 3)* was back in mother's life, and he was being abusive and physically violent towards her.
- During a home visit by the early help practitioner and health visitor, mother was seen to be struck with a phone by Partner 3.
- On occasions, the family home was observed as having deteriorated and was unkempt.
- Mother approached Lambeth Council requesting help to move away from Partner 3 and her address in Croydon.
- Concerns were also raised on several occasions about mother's alcohol use whilst Child R was in her care.

[1] The placement was with a not-for-profit organisation, with over 30 years of experience providing housing and accommodation support to predominantly black and ethnic minority women and their families in South London.

[2] The review was unable to establish any further details about this contact.

2.8 In light of the escalating concerns, the early help practitioner believed that Child R's case should be *'stepped up'* for a statutory social work response. Croydon Children's Social Care (CSC) were not in agreement. The rationale supporting this decision was that Child R's mother had expressed a willingness to work with early help services but not Croydon CSC.

2.9 Remaining worried, the early help practitioner met with a domestic abuse specialist for further advice. Their analysis was that mother could not manage the risks posed by Partner 3 due to her own vulnerabilities. A focussed risk assessment[3] for domestic abuse was suggested, with a view to making a referral to Croydon's Multi-Agency Risk Assessment Conference (MARAC)[4].

2.10 However, prior to this being completed, Croydon CSC were notified of several instances to which the police had been called. These involved reports of Child R's mother being drunk and unable to care for Child R and a sequence of incidents that included a disturbance and Child R's mother again being intoxicated (this time at her cousin's address), Child R's mother being arrested to prevent a breach of the peace and allegations that Partner 3 had taken Child R. On responding to the last incident, Child R's mother was observed with facial injuries. She explained these as having been caused in a fight with her cousin. The police did not believe this account and arrested Partner 3. He was later released given the absence of anyone willing to substantiate any allegation.

2.11 A few days later, the police attended mother's home address once again, this time to arrest Partner 3 who had been recalled to prison. Mother was observed with two black eyes but would not say how these were sustained.

2.12 On receipt of these police contacts, Croydon CSC spoke with Child R's mother. She denied being the victim of domestic violence and declined consent for an

[3] SafeLives Dash risk checklist for the identification of high risk cases of domestic abuse, stalking and 'honour'-based violence

[4] MARACs are regular risk management meetings where professionals share information on high-risk cases of domestic violence and abuse and put in place risk management plans.

assessment. This was appropriately overridden, and a statutory social work assessment commenced.

2.13 Whilst Child R's mother was reluctant to engage, she disclosed that Partner 3 had assaulted her, his friends were making threats and that she had left her home address as a result. Whilst agreeing to receive support from the Family Justice Centre (FJC)[5], the social worker believed that Child R's mother was minimising the domestic abuse she had experienced.

2.14 Continuing the assessment, a plan was made by the social worker to visit Partner 3 in prison and make a MARAC referral. Due to Covid-19, the prison visit did not take place. However, the MARAC referral was made, and the social worker visited mother who was staying with a friend. Soon afterwards, Child R and his mother were temporarily accommodated in Hackney.

2.15 Around the same time, an Independent Domestic Violence Advocate (IDVA) from the FJC was also told by Child R's mother that she had moved. Mother confirmed she had taken a number of safety steps, including changing her phone, blocking Partner 3's number and switching off any GPS location services. This provided some reassurance to the IDVA that Child R and his mother were safe.

2.16 On 6 April 2020, the assessment by Croydon CSC was concluded, highlighting that a child in need plan would have been initiated had Child R remained in the area. The assessment detailed that a referral would be made to Hackney Children and Families Services (Hackney CFS).

2.17 However, before this took place, Croydon MARAC made a referral to Hackney MARAC via Hackney's Domestic Abuse and Intervention Service (DAIS). On 7 April 2020, DAIS forwarded the details of this referral to Hackney CFS. As

[5] The FJC is a Croydon based service offering support, comfort and understanding to domestic violence victims and their families.

the referral indicated ongoing involvement by Croydon CSC, Hackney CFS decided no further action was needed at the time.

2.18 A few days later, on Friday 10 April 2020, the referral from Croydon CSC was received. This stated that immediate risk had been reduced as Partner 3 was in prison and Child R and his mother were relocating out of Croydon. The history of concerns identified in both Lambeth and Croydon were not included. Croydon CSC indicated that the threshold for child protection intervention had not been met locally and that Child R's mother was acting protectively.

2.19 Hackney CFS reviewed the referral the next working day, on Tuesday 14 April 2020, and decided to await the outcome of the Hackney MARAC (scheduled for 16 April 2020). The rationale was that the MARAC would be able to provide further details to inform the next steps. In parallel, Hackney CFS made requests for information from the police, probation, and DAIS.

2.20 At the Hackney MARAC, information was shared by DAIS that they had spoken with mother. She said she had a new and supportive partner (*Partner 4*), although given his identity was unknown, reassurance was limited in this context. An action was agreed for the MARAC chair to try and obtain Partner 4's details.

2.21 The next day, on 17 April 2020, Hackney CFS made telephone contact with Child R's mother. She confirmed her relationship with Partner 4, although stated she had not seen him since the beginning of the first Covid-19 lockdown. She denied being in contact with Partner 3 but believed he had been released from prison due to posts seen on social media. The details of Partner 4 were not established.

2.22 On Saturday 18 April 2020, an anonymous caller rang *Crimestoppers*[6] raising concerns about the welfare of Child R and his mother. The caller advised that a male at the address was being verbally and physically violent towards them.

2.23 Crimestoppers created a 'non-urgent intelligence report' and sent it electronically to the MPS. At the time, there was no 24-hour system in place to triage such reports and it was not seen until the afternoon of Monday 20 April 2020.

2.24 That morning however, a concerned neighbour called the police to report that they could hear what was believed to be a child being beaten. The caller also stated he believed an adult female was being assaulted. During the call, the police operator could hear a banging noise in the background. Officers attended the family's address and engaged with Child R's mother at the entrance to her room. Child R was naked from the waist up and a broken mirror was seen. Child R was not spoken to.

2.25 Mother explained that Child R had been throwing a tantrum for around twenty minutes and had finally calmed down around five minutes prior to the police arriving. She explained she was trying to her son dressed and he refused. The police determined there was no risk to either Child R or his mother and no action was taken.

2.26 A *Merlin notification*[7] relating to this incident was completed the same day. This stated '*Child was screaming while mum was trying to dress him. LAS can*

[6] Crimestoppers is an 'independent charity that gives people the power to speak up and stop crime – 100% anonymously' Crimestoppers will send information to the relevant authority with responsibility to investigate crime. The author understands that each force area have bespoke arrangements to determine how the information is shared with them. In terms of the MPS, it is understood that any information received to Crimestoppers is triaged by them (Crimestoppers) and graded. If an immediate police response is required, then a report is sent with a follow up telephone call to ensure police are aware of the priority required. In cases where they consider an immediate response is not required, an information report will be sent without any need for a follow up call.

[7] The 'Merlin' IT application is used to record the details of those vulnerable people aged 17 and under via a Pre-Assessment Check (PAC) and for details of vulnerable adults aged 18 or over via an Adult Come to Notice (ACN). MERLIN is also used for the recording and investigation of Sudden Deaths, Unidentified Persons/bodies and other found persons. Reports are recorded on Merlin to enable safeguarding teams to assess any risks or harm to individual children based on the report and any further relevant information. These reports are often shared with partner agencies to ensure a multi-agency approach can be taken to safeguarding.

cancel. No offences'. This report was not received by Hackney CFS until 22 April 2020.

2.27 On 21 April 2020, Child R sustained the serious physical injuries resulting in his hospitalisation.

3. Views of Mother

3.1 During her engagement with the review, Child R's mother shared an account of her experiences and the services that engaged with her and Child R.

3.2 Mother explained that she did not want to become pregnant due to having epilepsy. She reported being shocked when her pregnancy was confirmed and that she received different advice from professionals about whether to have an abortion. Mother said her family were very supportive at this time, but it was a difficult pregnancy in that she had more severed seizures than before.

3.3 Mother said she was the victim of numerous domestic abuse incidents perpetrated by Partner 3. Mother also spoke about being pregnant for a second time and Partner 3 being very angry with her. She miscarried this pregnancy.[8]

3.4 In response to the abuse from Partner 3, mother said that she tried to tell the police but was told there was no crime so they couldn't do anything. Mother also said she went back to Lambeth Council seeking help to move.

3.5 Mother said she wasn't referred to any domestic abuse services (prior to the referral to FJC). She said that she gave both the police and council information about what was happening to her but neither helped. Mother told the review that she hadn't told anyone else because she felt embarrassed.[9]

[8] Domestic abuse in pregnancy - NHS (www.nhs.uk)

[9] SafeLives (2015), Insights Idva National Dataset 2013-14. Bristol: SafeLives.

3.6 At the time mother was with Partner 4, she thought he loved and cared for her. She didn't see his behaviour as being abusive, rather she felt it was her fault, that she annoyed him and that she needed to do better. Child R's mother reported to the review that she can now see Partner 4 was controlling and manipulative. She had to do as he said, because she was expected to respect him.

3.7 Following sentencing, Child R's mother undertook the '*Freedom Programme*'[10]. She said this helped her gain strength, stand up for herself and reach out for help. She said she is fully aware of the impact that the domestic abuse had upon her son who saw her being hit and saw her crying. She said her son "*didn't deserve this*".

3.8 Mother also 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"*

4. Significant Adult Males

4.1 In the context of Child R's experiences in Lambeth, Croydon and Hackney, four adult males played varying roles in his life. Whilst the full extent of their involvement with Child `R is largely unclear, the following narrative provides a perspective on the dangers that these men posed to Child R, his mother and their previous partners.

[10] The Freedom Programme. Learn about domestic violence and abuse

4.2 **Partner 1**, Child R's biological father, is not known to have played a significant role in Child R's life. There are no known reports of any domestic abuse allegations involving Partner 1 and Child R's mother. He does, however, have a criminal history that involves theft, drugs offences and firearms / offensive weapons.

4.3 **Partner 2** assaulted Child R's mother whilst she was living at the hostel for young mothers in Lambeth. An argument took place between mother and another resident (who was the new female partner of Partner 2). The argument appeared to be trivial, although Partner 2 attended the hostel, grabbed Child R's mother, and punched her in the face. He was arrested, violently resisted, and assaulted three police officers. Partner 2 was charged with the assault on Child R's mother and separately charged with assaulting the police officers.

4.4 **Partner 3** has recorded offences involving theft, drugs, and firearms / offensive weapons. He also has a significant history of domestic violence and abuse. Prior to his relationship with Child R's mother, Partner 3 had police contact relating to domestic assault allegations with another female partner. In 2016, he was alleged to have falsely imprisoned her after she had ended their relationship.

4.5 In 2017, police responded to a call alleging that Partner 3 had assaulted his partner. On police arrival, the alleged victim was seen to have a lump under her eye and Partner 3 was arrested for assault. The partner stated she had slipped and fallen. In 2018, Partner 3 was convicted for possession of Heroin with intent to supply. He was sentenced to 30 months' imprisonment. His release condition showed him to be residing with Child R's mother at her home address.

4.6 In 2020, there were four incidents resulting in police involvement:

- *The London Ambulance Service (LAS) was called to Child R's mother's home address. Mother was pregnant and was bleeding. Upon LAS arrival, Partner 3 was so aggressive the paramedics called police to assist.*

- *Child R's mother was involved in a domestic incident with another family member where she had been drinking and acting aggressively. This resulted in her arrest. Mother was taken home with Child R by the police, where Partner 3 agreed to take care of them both. Approximately two hours later, mother called police stating that Partner 3 had taken Child R away from her. Upon police arrival, mother had what appeared to be recent injuries to her face, which she claimed to have received during the earlier fight with her cousin. Partner 3 was arrested but no further action taken.*
- *Police re-attended mother's home address a few days later and arrested Partner 3 who had been recalled back to prison. On police arrival, mother was seen with two back eyes, however, she would not explain how she had received the injuries.*
- *Mother reported to police that she had received threats from Partner 3's friends that when was released from prison, they would help him take Child R away.*

4.7 **Partner 4** has a substantial criminal history that includes allegations of assault, burglary, and sexual assault. He is a serial domestic abuser and has been diagnosed with Schizophrenia. His criminal behaviour dates from 2008 when he was just 13 years old.

4.8 The first allegation of domestic abuse resulting in police attendance occurred in 2010. There were three incidents that year that involved serious physical violence, the use of a knife and threatening behaviour against his then partner. In 2017, there were four recorded incidents of domestic abuse requiring police involvement. Again, these all involved serious physical violence and severe levels of harassment. During some of these incidents, Partner 4's baby was present. In 2019, two incidents of concern were noted. Partner 4's partner was observed by police officers to have sustained a facial injury after receiving a call about a disturbance at her home address. Another incident involved the following:

'He (Partner 4) damaged her property, grabbed her by the hair pulling her to the ground threatening her with scissors and a knife. He then assaulted her by

banging her head against a wall. He wrapped a phone cord round his hands and held it against her throat. She was further assaulted before she was able to leave the house and contact police.'

5. Findings & Recommendations

5.1 The review identified three underlying themes when evaluating the sufficiency of multi-agency safeguarding practice involving Child R.

- The first relates to **information sharing**. Whilst a repeating issue in most reviews, this theme primarily concentrates on the arrangements for transferring community health records and the transfer of cases between local authority areas.
- The second theme involves the ability and confidence of safeguarding practitioners **to recognise risk and act with authority in cases involving both domestic violence and child abuse**.
- The third theme highlights the importance of **safeguarding practitioners dynamically including relevant adult males in their assessments of risk**.

5.2 How these themes manifested in practice are set out in the following analysis of the questions posed to the review. They are the key issues for the involved safeguarding partnerships to take forward in terms of learning and improvement.

What was the sufficiency of the transfer process when Child R moved into Hackney?

5.3 When considering this question, the review also took account of the family moving between the other local authority areas where they lived. The overall findings align with two of the 'stubborn challenges' identified by the Child

Safeguarding Practice Review in its second annual report[11]. These are, '*understanding what the child's daily life is like*' and (consistent with the review's first theme) '*sharing information in a timely and appropriate way*'. In the context of how agencies worked with Child R, these two issues were fundamentally interconnected.

5.4 Finding 1: Poor and untimely information sharing hindered practitioners gaining a full understanding of what Child R's daily life was like and the potential risks that he was facing.

5.5 Whilst there were several occasions where information sharing could and should have been better, significant disruption was identified in the context of Child R's community health records. The transfer of these records did not adhere to Public Health England Guidance.[12]

5.6 For example, following Child R moving from Lambeth to Croydon in early 2019, it took 17 months for his health records to be transferred. By the time these arrived in Croydon, the family had already moved to Hackney. Over this period, there is no evidence that the records were proactively requested by Croydon's Health Visiting Service or that the health visitors ever made contact. The delay with the transfer of records was reported as being due to an administrative error.

5.7 The consequences of this error meant that the health visitor in Croydon had minimal information regarding the family and therefore limited ability to provide a focused, risk assessed service to a vulnerable family. It is unclear why there were no attempts to retrieve the records or escalate concerns that they hadn't been received. This could have been raised as an issue during supervision and/or reported as a clinical incident. The background information from Lambeth was significant and could have prompted the Croydon practitioners to seek out help for the family much earlier.

[11] The CSPR Annual Report 2020

[12] Guidance to support commissioning of the healthy child programme 0 to 19: Commissioning guide 2: model specification (publishing.service.gov.uk)

5.8 The delayed transfer of health records was also a feature in the move of Child R and his mother from Croydon to Hackney. It was not until after Child R had been admitted to hospital that the Croydon Health Visiting service contacted its counterpart in Hackney. Indeed, despite the family moving a month before, the national NHS spine still showed Child R's address as being in Croydon. Whilst a handover report was completed, it took two to three weeks for the records to be finally transferred. The delay was reported as being caused by a backlog due to Covid 19.

5.9 A swift transfer of records at this point is likely to have engaged Hackney practitioners much earlier, with opportunities created to see Child R and gain reassurance about his welfare and the circumstances in which he was living. As it was, health visitors in Hackney were not aware of the family's residence until the MARAC notification on or around 9 April 2020.

5.10 Recommendation 1: Public Health Community Nursing services engaged in this review should review their policies covering the transfer and receipt of community health records to ensure these are sufficiently robust in respect of defining the process and management oversight of the timeliness of record transfer, case closure and escalation (including systems to request records if not received).

5.11 Less than effective information sharing also featured in the referral from Croydon CSC to Hackney CFS. As part of this process, there was neither the history of domestic abuse included nor an account of the involvement with Child R's mother whilst living in Lambeth. Overall, the information shared failed to reflect the full reality of Child R's circumstances and hence limited the understanding of need and potential risk.

5.12 Whilst additional information had already been shared via Hackney's MARAC, the referral from Croydon provided a degree of false reassurance. The thrust of its detail indicated that mother was acting protectively by fleeing Croydon. Whilst arguably true, when seen in the context of the family's history, there was more than just the contemporary issues to consider. These do not appear to

have been afforded the weight they required. Taking a holistic view, the patterns of previous domestic abuse and mother's alcohol use were equally significant. Their inclusion, in the opinion of the review, may have facilitated a more proactive response from Hackney CFS.

5.13 As it was, the referral's 'tone' is likely to have influenced the decision to await the outcome of the Hackney MARAC. The rationale for this decision was that the MARAC would help inform the assessment of risk (i.e. likely length of sentence, father's offending history, mother's protective capacity). Delaying decision making in this way was not in line with statutory guidance[13], but perhaps reflective of the priority that Child R had been afforded based on the information that had been shared.

5.14 Recommendation 2: Safeguarding Children Partnerships involved in this review should seek reassurance that their respective practice guidance and training sufficiently emphasises the need to include relevant historical information as part of making a referral to local authority Children's Social Care.

5.15 The referral process itself is also believed to have introduced a level of ambiguity about the status of Child R's case. In the opinion of the review, had this been clearer, it is possible that the quality of information sharing may have been improved and the context of Child R's needs better understood.

5.16 To explain further, the review was uncertain whether the contact from Croydon CSC was a request to 'transfer' Child R's case or a referral requiring a decision from Hackney CFS about what action was required? There are subtle, yet significant differences between these two processes that involve procedural requirements, the expectations placed upon professionals and importantly, how families should be engaged.

[13] Page 35 Working Together 2018

5.17 The chronology shows that Croydon CSC correctly completed its assessment despite the family having moved. This concluded that Child R would have been a 'child in need' had he remained in Croydon. This information was shared with Hackney CFS as a new referral and was subsequently 'processed' as such.

5.18 Arguably, Hackney CFS didn't need to do this. Had the London child protection procedures been followed, the contact from Croydon could have resulted in a child in need planning meeting being convened by Hackney.[14] As it was, practice was focussed on what to do with the referral as opposed to facilitating the smooth transfer of a child with recognised needs into a new area.

5.19 Whilst there are no guarantees this would have changed the outcome for Child R, the focus of practice might have been different. Activity to facilitate a transfer could have concentrated efforts on sharing information, as opposed to determining whether thresholds had been met. The Croydon social worker could have visited Child R and his mother to explain next steps, perhaps undertaking this jointly with a practitioner from Hackney.

5.20 Furthermore, whilst there is no formal requirement to hold a meeting to discuss the transfer of a 'child in need', this would undoubtedly have been good practice. The family's situation was complex and such structured discussions are likely to have helped with understanding Child R's lived experience and practitioner's reaching agreement as to what actions were necessary.

5.21 The arrangements to transfer information about Child R should also have been subject to the family's consent. Whilst similarly applicable in a referral, there was no evidence that this was explicitly sought. Again, had this been done, opportunities are likely to have been created for dialogue with Child R's mother and observation of Child R. In the review's opinion, this would have facilitated

[14] For children who have moved Local Authority areas, paragraph 6.1.4 of the London CP procedures state: *'If the outcome of the assessment is that the child should be the subject of an initial child protection conference **or child in need planning meeting**, then that conference / meeting should be arranged by the receiving authority, i.e. in which they are then to be found / residing'.*

a more robust 'handover' of the case and less reliance on the written referral to convey the needs of the family.

5.22 The review acknowledges the national demand pressures on local authority children's social care and the workload incentives that might exist to rapidly 'hand-off' cases once a family has moved. However, it is at times of transfer that risk can escalate. '*Relationships with relatives, friends, schools and statutory services are likely to be fractured as a result of such moves; alternatively, those seeking to avoid the intrusion of statutory services may welcome the opportunity to severe relationships with those that have begun to understand them*.'[15]

5.23 Recommendation 3: The London Safeguarding Children Partnership should review the procedures governing the transfer of children in need cases. These should be explicitly strengthened to define the requirement for formal handover meetings when children are on a child in need plan, when they have been assessed as being a child in need (prior to a plan being developed) or when families have moved mid-assessment. Much greater emphasis should be placed on the arrangements to facilitate case closure in one area and a case opening in another.

How effective were individual agencies and the multi-agency partnership in identifying potential risk and protecting Child R from harm?

5.24 The review found that the quality of practice was variable in response to domestic abuse and child abuse (the review's second theme). Weaknesses were evident in both historical practice and the contemporary intervention immediately prior to Child R being hospitalised.

[15] 6.1.1 London CP Procedures

5.25 Finding 2: There was a lack of authoritative practice in response to concerns about domestic abuse and child abuse. This meant that opportunities to help and protect Child R through statutory intervention were missed.

5.26 There is a substantial amount of evidence reinforcing the impact of domestic abuse on the safety, welfare and longer-term development of children and young people. The review does not need to set this out in any detail, other than to reinforce that domestic abuse continues to feature nationally as one of the main issues of concern in cases referred to Children's Social Care[16]

5.27 Positively, most, if not all safeguarding organisations will have domestic abuse referenced somewhere within their priority schedule. Indeed, front-line practitioners will ordinarily have opportunities for professional development and access to a range of tools to use when engaging with families.

5.28 With the existence of such arrangements, it is arguable that practitioners should have demonstrated a much more authoritative approach when responding to the concerns involving Child R's and his mother. The fact that this didn't happen not only raises questions about practitioner knowledge and competence, but also whether the sheer volume of cases involving domestic abuse have de-sensitised the system. By this, the review suggests a hypothesis that thresholds for concern may be too high given domestic abuse is being encountered on a much more routine basis.

5.29 There were several examples where practitioners should have been more robust in their response to domestic abuse:

- An incident of Child R's mother being hit with a phone by Partner 3 was observed by a health visitor and early help practitioner. There was no evidence of protective action being taken or consideration this should be escalated to CSC.

[16] Factors end of assessment CIN

- The decision by Croydon CSC not to accept a referral, despite established patterns of concern, police involvement and the identified risk posed by Partner 3, was a missed opportunity to secure a clear plan to help and protect Child R.
- The lack of any challenge to this decision was also a missed opportunity, particularly given the advice provided by a specialist domestic abuse practitioner on the level of existing risk.

5.30 Recommendation 4: Local Safeguarding Children Partnerships involved in this review should promote a programme of training and routine awareness raising that reinforces the seriousness of domestic abuse in the context of children's safety.

5.31 Recommendation 5: Local Safeguarding Children Partnerships involved in this review should satisfy themselves that local threshold tools are sufficiently describing the significance of risk associated with domestic abuse, particularly where such abuse forms a repeating pattern.

5.32 Additional lessons for practice in response to domestic abuse were shared as part of mother's account to the review. Her statements reinforce the need for all practitioners to recognise the impact of coercion and control. Victims of domestic abuse are unlikely to disclose the harm they are suffering without skilful professional interaction, persistence, and assurances of safety.

5.33 Reading between the lines of what children and families say and communicate (as well as what they do not say) involves time, imagination and the most proficient of relational skills. All safeguarding practitioners have a responsibility to create the conditions in which their talents and resources can focus upon understanding what life is like for children.[17]

[17] The Child Safeguarding Practice Review Panel Annual Report 2020 Patterns in practice, key messages and 2021 work programme.

5.34 Linked to the effectiveness of practice in respect of domestic abuse and child abuse is the focus on the perpetrators of such harm. The review makes the following finding.

5.35 Finding 3: Safeguarding Children Partnerships need to find better ways to embed a culture of practice that routinely includes adult males when assessing need and risk to children.

5.36 There were missed opportunities to better understand the patterns of risk that Child R was being exposed to. When reading the stark accounts of the behaviour of mother's partners, it is perhaps unusual that the professional network didn't have access to this information, seek it or use it to determine the circumstances in which Child R was living.

5.37 The absence of this '*chronology of concern*' from the thinking of professionals is relevant to the third underlying theme of this review – the need for practitioners to properly consider the roles of adult males in the lives of children.

5.38 Again, there is comprehensive evidence identifying this as a repeating weakness in practice. This has been most recently emphasised in the Child Safeguarding Practice Review Panel's report on safeguarding children under 1 from non-accidental injury caused by male carers.[18] The narrative in section 16 of this report and its focus on engaging and assessing men is entirely relevant to this review.

5.39 Recommendation 6: Local Safeguarding Children Partnerships involved in this review should all develop a coherent plan for improving how practitioners engage with adult males that are significant to the lives of children.

5.40 Opportunities for practitioners to identify risk were also seen in the days immediately preceding Child R being found unconscious. These largely fell to

[18] The Myth of Invisible Men, CSPRP, Sept 21

the police and link to the review's second theme concerning authoritative practice.

5.41 Finding 4: Opportunities were missed to understand Child R's circumstances in the context of risk. This arose due to a lack of professional curiosity and intervention that failed to put Child R at the heart of practice. He wasn't seen, heard and helped.

5.42 The anonymous call to Crimestoppers and the subsequent call made to the police were not solely focused on domestic abuse. Both reports indicated that a child was being harmed – child abuse.

5.43 Given this clarity, there was an error in judgement by Crimestoppers to grade its report as 'non-urgent'. This resulted in no immediate oversight by the police, no immediate response and no help or protection for Child R. The review understands that procedures governing the oversight of Crimestoppers' reports have since changed, with enhanced scrutiny mitigating the risk of such events being repeated.

5.44 With regards to the direct police report, the initial response was appropriately swift. This appears to reflect the seriousness with which the report was taken, and the fact that a child was involved.

5.45 However, on reaching the threshold of the family's room, proactivity weakened. Contact with the family did not move beyond the front-door and whilst Child R was seen, he was not spoken to. Opportunities were missed to look more closely at Child R's physical condition (relevant given the historical injuries that were identified) and mother's account appears to have been taken at face value. There was a lack of professional curiosity.

5.46 Furthermore, whilst details were 'diluted' when radioed through[19], the concerns were sufficient for officers to have been far more inquisitive in their questioning of mother and observations of Child R. There was equally no attempt to identify the details of Partner 4. Had these been established, they would undoubtedly have prompted a response beyond no further action.

5.47 Unfortunately, this didn't happen. The police withdrew, the Merlin notification to Hackney CFS was sent late and Child R was seriously harmed the following day.

5.48 The lessons identified from this short window on Child R's life relate to the importance of basic safeguarding practice. For the police, standards for such practice are clearly set out by the College of Policing[20] and MPS procedure. Of critical importance is the need for practitioners to be child centric. However, despite the nature of the reported concerns, at the point of initial contact, there was no evidence that officers made '*every effort'* to see and speak to Child R or *'establish that he was unharmed and not at future risk of harm*'.

5.49 Recommendation 7: To ensure officers are maintaining a clear focus on the safety and welfare of children, the Central East Basic Command Unit of the MPS should continue its implemented process of dip sampling recordings of Body Worn Cameras.

Did the Covid-19 lockdown arrangements have any bearing on individual or multi-agency practice in Hackney and / or the serious harm inflicted upon Child R?

5.50 At the time of Child R's hospitalisation, England was experiencing its first national lockdown because of the Covid-19 pandemic. The review found that these arrangements had some bearing on practice.

[19] . Officers were told that a child was being abused but there was no mention of the male or frequent disturbances. Technical difficulties meant that the lead officer was unable to access and read the full details of the concerns.

[20] Police response to concern for a child, College of Policing

- Staff shortages caused by the pandemic affected the administration arrangements in several services. For example, despite being approved for transfer in late April 2020, Child R's community health records were not sent to Hackney until mid-May 2020. Pressure on administration capacity also led to a delay in the circulation of the minutes of the Croydon MARAC meeting on 9 April 2020. These were not published until the 1 May 2020.

- Covid-19 restrictions measures meant that the Croydon social worker was unable to visit Partner 3 in prison. Whilst good practice to attempt such contact, this limited the available information within the assessment. It remains uncertain as to what value this would have added to the overall analysis of need and risk.

- The Hackney MARAC held on 16 April 2020 discussed 21 cases of which 16 cases included children. This was viewed as a busy meeting and an early indicator of the increasing cases of domestic abuse seen throughout the pandemic.[21]

- There was no evidence to indicate that Covid-19 influenced the actions of attending officers not to enter the family's room.

Did any other practice issues, either single or multi-agency, have any bearing on the serious harm inflicted upon Child R?

5.51 The review identified two additional practice issues to inform future learning and development requirements across the three boroughs where Child R and his mother lived.

5.52 **Finding 5: On occasions, practitioners lacked curiosity about significant aspects of Child R's mother's background which impacted on the assessment and planning of services to ensure that Child R and his mother were safe.**

[21] The National Domestic Abuse Helpline database reported a 34% since the first lockdown in March 2020.

5.53 Whilst an issue already identified as part of the police response in April 2020, there were other examples:

- During the antenatal assessment, Child R's mother answered 'yes' to Whooley questions[22], and disclosed the family had previous social care involvement owing to physical violence perpetrated by a family member when Child R's mother was aged 7 years. These issues didn't feature heavily, if at all, when considering what support Child R and his mother might need.

- As part of a health visitor assessment, Child R's mother reported she had epilepsy and was being treated by the specialist service at Kings College Hospital. Given mother was living alone with Child R, there was a lack of exploration about how often the seizures occurred, how well controlled they were and what contingency arrangements were in place to ensure Child R was safe.

- There was a repeated lack of curiosity about the adult men involved in Child R's life. Beyond the Croydon social worker planning to visit Partner 3, there was no evidence of any real focus on what these individuals meant in the context of Child R's safety and welfare.

5.54 **Finding 6: Signs of possible neglect and the identification of patterns of cumulative harm weren't effectively identified by safeguarding practitioners.**

5.55 The patterns of behaviour and dysfunction within Child R's family appear to have been accepted as the norm. These should have prompted practitioners to focus on the potential impact of these issues in respect of cumulative harm. This was particularly relevant in respect of Child R's repeated exposure to domestic abuse, neglect, and other Adverse Childhood Experiences.

[22] A case finding tool for depression

5.56 For some practitioners, deficits in information sharing limited their understanding of these patterns. For most, however, it appears that these issues weren't being systematically considered as they should have been.

5.57 Understanding the context of a child's life is key and understanding this context must form a priority for all practitioners. This is not a new feature of good practice and whilst safeguarding can be complex, some of the steps to understand the lived experience of a child are not - see children and families, talk to them and listen to what they are saying.