Child Safeguarding Practice Review

Learning identified from Family A

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1 Introduction

1.1 The South Gloucestershire Children's Partnership (SGCP) agreed to undertake a Child Safeguarding Practice Review (CSPR) by considering the engagement of professionals with a family of three children to be referred to as Family A.

1.2 When the children were aged four, three and one, their father died and their mother has been convicted of his murder. At the time of their father's death, the children were on child protection plans and a decision had been made to implement the Public Law Outline due to concerns about domestic abuse, the impact on the children of the parent's poor mental health and substance misuse, and the emotional neglect of the children.

1.3 The rapid review that considered the case in the days following the father's death, concluded that although the children in the family were not physically harmed themselves, there was evidence of emotional harm over time, culminating in one of the children witnessing his mother killing his father. It was decided that it met the criteria for a CSPR and that learning would be identified.

1.4 While there is potentially learning about the pre-birth assessment/s in the case, the review agreed to concentrate on more recent practice.

1.5 The learning is in the following areas:

- Understanding what the domestic abuse involves in a specific relationship, to then consider how this will impact on the children
- The need to consider other apparent risks alongside domestic abuse, in this case parental mental health, substance and alcohol abuse

- Information sharing of adult information and plans (such as MARAC plans) with those providing services to the children
- The need to seek, share and consider information with and from the GPs of the adults living with children
- Involving fathers in plans, even when there is domestic abuse and/or they do not live with the children
- All professionals need to consider and understand the impact on a child when their parent is vulnerable with a history of adversity and trauma in their childhood and in their adult relationships
- The need for preventative and early help services for perpetrators of domestic abuse
- The importance of considering information from extended family

2 The Process

2.1 An independent lead reviewer[1] was commissioned to work alongside local professionals to undertake the review. The detailed information provided to the rapid review meetings was considered and each agency involved was asked to provide further reflect on their agency involvement and consider whether any single agency recommendations were required.

2.2 A face-to-face multi-agency meeting with professionals involved at the time was held for discussions about the case and the wider systems in which they work.

2.3 A panel of local managers and safeguarding leads worked with the lead reviewer to identify the overall learning and recommendations included in this report.

3 The lead reviewer and a representative of the SGCP met with the children's mother, maternal grandmother, maternal grandfather, and paternal grandfather with the aim of identifying any learning from their perspective[2]. Their views and this learning are included in this report.

4 The Learning

4.1 The learning identified for the safeguarding system and partnership is highlighted below, followed by detailed and case specific analysis.

Assumptions about domestic abuse, without a clear assessment of what the abuse involves and who the victim/perpetrator is, can lead to plans for children that are not reflective of their experience and therefore do not mitigate risk

4.2 Domestic abuse and the impact on children are a major concern for professionals working in safeguarding roles. 80% of the CSPRs and Serious Case Reviews published in 2021 included concerns about children living in families where domestic abuse been an issue at some stage. Domestic abuse was identified in this case from 2016, prior to the first pregnancy. Both parents

[1] Nicki Pettitt is an independent social work manager and safeguarding consultant. She is an experienced lead reviewer and entirely independent of the SGCP

[2] Paternal Grandmother was approached but did not feel able to speak to the review

were teenagers at the time of the pregnancy. This review has concentrated on the most recent concerns.

4.3 Reports about domestic abuse increased from January 2021, with the police attending incidents between the mother and the father. There were also allegations of harassment at the time from both parents towards Father's ex-partner who was the mother of another of his children, and similar allegations made by them about her. In 2020 Mother was issued with a two-year Protection against Harassment Order in respect of this[3] as she had not attended a victim awareness course. Further allegations were made in 2021 and extensive investigations were undertaken by the police. The matter was complicated by Mother making counter allegations and the case was filed in February 2022 with no further action due to insufficient evidence. Children's social care (CSC) in South Gloucestershire were not aware of the on-going harassment concerns until a strategy meeting was held in July 2021. Information was regularly shared by the police with CSC in another area regarding the child with the previous partner but not in respect of the children living with the child's father. This was an oversight, as the children in South Gloucestershire may also have been impacted by the alleged behaviour of or to their parent's.

4.4 Mother's GP was aware of the police notifications[4] about domestic abuse between mother and father. Mother and the children were registered at the same GP surgery. The GP also had an awareness of Mother's alcohol consumption, so they made a referral to CSC that focused on concerns about the impact on the children of both matters, who were all under 5 years old at the time. This led to an assessment and from May 2021, the children were made subject to child in need (CiN) plans. The family agreed to work with professionals and to separate. Professionals had ongoing concerns in the months that followed, and the children were made subject to a child protection plan under the category of neglect in August 2021. The ICPC noted that there was a significant history of domestic abuse within the relationship, often witnessed by the children, accompanied by parental mental health concerns (largely depression) and drug (cocaine) and alcohol use, leading to neglect of the children. A lack of meaningful engagement with the CiN plan contributed to the decision for child protection planning. The review CP conference held three months later recorded the professional concerns that the couple were not separated, as they claimed, and were lying to those involved in the child protection planning. A decision to initiate the Public Law Outcome was made.

4.5 There is evidence that the parents were both potentially perpetrators and victims of both physical and verbal abuse in the relationship, and there was a pattern of them making counter claims and allegations. It is clear from the information shared by agencies that most services viewed the children's mother as the victim and their father as the perpetrator however, and they both received

[3] The order stated that Mother should not contact the ex-partner or her mother, or post anything about them on social media.
[4] In South Gloucestershire Sirona (the service with responsibility for health visiting and school nursing) receive the report of an incident. If there are children under 5 in the household, it is then shared by them with the children's GPs, but not with the GP for the adults.

services appropriate for this. Next Link[5] had both parents listed as victims, but their services are for predominantly for women and children, and they worked with Mother. Father was referred to and engaged with Drive, a service that works with 'high-harm, high-risk and serial perpetrators of domestic abuse to prevent their abusive behaviour and protect victims'.[6]

4.6 In this case it was not necessarily as simple as one victim and one perpetrator, and professionals need to recognise that domestic abuse is not always this straightforward and that a deeper understanding of relationship dynamics is required. While the abuse and violence superficially appear to have been two-way in this household, research shows that while there might be unhealthy behaviours from both partners in a relationship, there is almost always a primary perpetrator who tends to have the power and control, and this requires an assessment to ensure that professionals were clear about the situation. Having this knowledge was important, as it would have provided clarity to professionals about how they needed to work with the couple to safeguard the children. Truly mutual abuse is very rare, so specialist domestic abuse advice should be taken where this appears to be the case. Professionals working in children's services need to have an open mind when mutual abuse is evident regarding where the power lies if they are to plan to protect children from the impact.

4.7 Conversations about the possibility of mutual or bi-directional abuse and their views on the power in the relationship were not held with either parent in this case. This was due to the limited time available to specialist agencies to engage with the parents in respect of this. Drive had seen Father on just three occasions before his death. For the work to be meaningful, a good relationship with trust is required. This takes time to build. Drive can undertake a bi-directional abuse assessment with perpetrators, known as 'who does what to who' to understand the complexities in an abusive relationship. They had not begun this work with Father. System's learning is evident about delays in referring Father to Drive, which are linked to the issues with MARAC prior to 2021, that are considered below. This means however that professionals from children's service were working with the family with a simplistic view of the domestic abuse, that did not include any specific assessment of how domestic abuse manifested in the parent's relationship. In South Gloucestershire there is an awareness amongst domestic abuse professionals and those involved with the MARAC of the Respect Toolkit for work with male victims[7], and plans to further promote and consider this.

4.8 In this case there needed to be an acknowledgement of the apparent bi-directional abuse and the resulting need to understand the detail and complexity of the domestic abuse in the parent's relationship. Luke Martin on the Safe Lives blog explained in 2018 how challenging it can be for professionals when presented with counter-allegations. He adds that with 'appropriate understanding and training, we can identify the power dynamic and our primary victim. By doing

[5] Next Link is a local specialist domestic abuse service for women and children
[6] Mother was not referred to Drive as she was not seen to be a repeat or serial high-risk perpetrator, and because Father had not been identified as a high harm victim to MARAC, which is part of the process for Drive involvement.
[7] https://hubble-live-assets.s3.amazonaws.com/respect/file_asset/file/24/Respect-Toolkit-for-Work-with-Male-Victims-of-Domestic-Abuse-2019.pdf

this we can increase safety and manage risk. Always start from the point that the abuse is never equal and oppositional, even if that is how it is presented to you in the first instance.'[8] Professionals also need to keep an open mind to whether the primary victim may be male. In this case it is not known what the power dynamic was, and whether Mother was a perpetrator or whether she was the primary victim who was responding to abuse. She was certainly the most obviously vulnerable due to her traumatic experiences as a child, her care experience and as a repeat young mother. It was pointed out during the review that she had been pregnant for 40% of her adult life by the time of the incident, and it is known that the risk of domestic abuse increases significantly during pregnancy.

The father[9] needs to be fully considered and involved in any assessments and plans in respect of their children, including when domestic abuse is apparent or when they do not live with the children.

4.9 It is not known where the power lay in the relationship between the parents in the case being considered, but because domestic abuse is largely seen as a crime that is perpetrated by men against women, this was accepted as the situation without a thorough assessment of what the abuse entailed. There were several indicators in this case that the parental relationship and the domestic abuse was not straightforward. One of the children told their childminder that his mother hit his father, there was information shared at a strategy meeting in 2019 that Mother had punched Father, and there were suspected instances of both verbal and physical abuse from her to him. There was no consideration at the time of whether the father was a victim or whether 'violent resistance'[10] from Mother was what was occurring.

4.10 During her pregnancies with her three children Mother did not disclose any domestic abuse to midwives who undertook routine questioning. Those who were aware of historic police reports from Mother that Father had been aggressive asked her about this during her 2020 pregnancy and were told by Mother that things were 'good now' and that she felt safe. It Is not unusual for the victims of domestic abuse to misrepresent what is happening from fear of what would happen if they disclosed, or an acceptance of abuse within a relationship. The 2021 national CSPR The Myth of Invisible Men[11] asked valid questions about the effectiveness of routine questioning about domestic abuse when there is 'limited capacity to develop trusting relationships with parents' and 'when women frequently may not recognise their relationship as coercive or controlling'. The review report also states that neither the midwives nor health visitors that they spoke to were able to 'provide many examples of these questions being responded to positively or leading them to different service responses.' In this case Mother told this review that she was afraid of telling the truth about the relationship as she feared the children would be removed from her care.

[8] https://safelives.org.uk/practice_blog/managing-counter-allegations
[9] It is acknowledged that there may be a same sex partner or a man who is not the birth parent living with the children.
[10] In this context violent resistance is a form of self-defense, when violence is perpetrated by victims against their partners who have been domestically abusive.
[11] 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

4.11 Routine questioning remains expected good practice and it is largely in place in South Gloucestershire, where women are asked regularly, when having contact with health agencies, whether domestic abuse is an issue in their homes or relationships. The question needs to be worded to enable women to speak about being either a victim or a perpetrator of domestic abuse, although the above findings of the national review need to be considered. A study conducted by Bristol University states that men seldom get asked about their domestic relationships by health professionals, and very rarely about whether domestic abuse is a feature, including when there are children in the family. This is alongside a cultural norm where professionals less readily recognise male victims, and where initial professional qualification training for those in health and social care jobs may not cover the importance of practice that always includes fathers. There is good practice in A&E in the area however, where a domestic abuse IDVA is placed, and they report that male victims are regularly being supported. There is insufficient guidance at present nationally around perpetrator enquiry however, including how to respond in the case of a disclosure.

4.12 At the time of this review being completed there was still no clear picture of who had the power to abuse in the relationship, and whether the other parent was pre-empting, responding, or defending themselves. Mother told the review that she was a victim of physical domestic abuse throughout the relationship. She made specific allegations of physical domestic abuse from Father at the time, including of a sexual assault, while Father made no specific allegations. However, it is known that men are less likely to come forward and speak about their experience of being a victim of domestic abuse than women, however. This is likely due to societal pressure, a fear of stigma, and support services either being unavailable or not as well publicised as support for female victims. The Office for National Statistics estimates that 1.6 million women and 757,000 men reported abuse in 2020. While most domestic abuse is undoubtedly inflicted on women by men, men can also be victims in both same sex and mixed gender relationships. The charity Mankind point out that while one in four women will be a victim of domestic abuse in their lifetimes, one in seven men will be victims too. They also point out that less than 5% of survivors being supported by services are male[12]. Specialist emergency accommodation such as refuges are also extremely limited for male victims.

4.13 There were opportunities for professional curiosity about domestic abuse in respect of Father. In August 2019 he attended for medical attention with injuries to his hand, stating he punched the wall when drunk the previous night. In July 2020 he attended with a foot injury and in September 2020 with a knee injury. They were presented by him as work related, which was feasible. More significantly, with hindsight, around a week before the fatal incident, Father attended the minor injury unit with an injury to his elbow. He claimed it was a football injury received when tackled and the result of a boot stud. The injury was recorded as a 'superficial grazing to left forearm, small healing/scabbed 1cm laceration.' The injury was recorded as consistent with Father's explanation. During the court case which resulted in Mother's conviction, it was accepted that this had been a previous injury inflicted by Mother. This was not known at the time by any agency. Members of the

[12] https://www.mankind.org.uk/statistics/research-male-victims-of-domestic-abuse/

family are now thought to have been concerned about this injury at the time, but this was not then shared with professionals.

4.14 Father was not asked about domestic abuse as routine enquiry is not usual practice in all admissions and is less likely to be considered if it is a man who is presenting with injuries. Medical staff do not tend to ask about parenthood as part of their admission assessment for men. However, on the last attendance to the minor injuries unit it was recorded that a safeguarding checklist was completed, and that the account given was consistent with the injury. This is good standard practice.

4.15 As Father was registered with a different GP than Mother and the children, his GP was not aware that domestic abuse was an issue in the household or that the children were on a child protection plan. This is an issue that is regularly found in reviews of this type, and it has been identified as requiring further work nationally. GPs are in a unique position regarding safeguarding as they hold information about a person's health history by way of their own health records and information shared with them from other health providers and agencies. They are potentially able to consider new information alongside this history, but only if they are asked. Work is being undertaken in South Gloucestershire to improve the information sharing in respect of the GPs of children. This review shows that domestic abuse notifications and information from MARAC[13]s needs to be shared with all relevant GPs, including those for the adults living with children, and that the GPs for the children and both parents (or other adults living in the home) are consulted when social work assessments are completed, that they are all are invited to child protection conferences, and so on. There needs to be a review of documentation to ensure that the GPs for each family members are recorded and contacted. A recommendation has been made in respect of this.

4.16 A Multi-Agency Risk Assessment Conference (MARAC) is a meeting where representatives from statutory and voluntary agencies share information about high-risk victims of domestic abuse, with a co-ordinated action plan being produced to increase victim safety. Domestic abuse had been known about in the couple's relationship for some years before the case was subject to a MARAC in November 2021. At the time there were limited numbers being referred to MARAC due to the criteria being clear high-risk cases only. It was also identified that practitioners across different agencies did not know how to complete a DASH risk assessment and the benefits of MARAC. At the time there were staffing issues in coordination of the MARAC, and this led to the process not being actively promoted across agencies as it was in other areas. This review was told that it is likely that this case would have come to MARAC and thus DRIVE earlier now.

4.17 The mother had engaged with Next Link for rehousing and a DVPO had been issued in this case before it came to MARAC. The referral of the father to DRIVE was not completed until after the MARAC however, as the system must ensure that the cases with most risk receive this limited and valuable service. He was said to be engaging well at the time of his death in March 2022 but had only received three sessions. Had the case been referred for a MARAC prior to this there could

[13] Multi- Agency Risk Assessment Conference

have been earlier involvement with the father and a consideration of what exactly the domestic abuse entailed in the case. This work would have been beneficial for the children and the team around them.

4.18 A Domestic Violence Protection Order (DVPO) was issued by the police and was in place in July/August 2021, prior to consideration at the MARAC meeting. DVPOs can be positive as they remove the pressure on the victim to act, as a magistrate issues them following the police issuing a Domestic Violence Protection Notice (DVPN). They are also timely as a DVPN can be put in place with immediate effect. Other domestic abuse orders require the victim to feel ready to act, which is notoriously difficult. The police ownership of the orders also means that there can be checks by neighbourhood police teams to monitor compliance. They are most likely to be effective when the professionals working with the children are aware of the DVPO and when this is included as part of any child in need or child protection planning, however. They were very new at the time, and there is no evidence that the family health visitor knew that a DVPO was in place. The children's social worker informed the police of a breach known to them, which shows that they were aware. There was no reference to the DVPO in the records for any of the multi-agency meetings in respect of the children. A recommendation has been made.

4.19 A Joint Agency Thematic Inspection (JATi) that considered the multi-agency response to children living with domestic abuse, 'Prevent, Protect and Repair' was published in 2017 and found a pattern of agency focus on the 'victim' with them having the responsibility to protect the children, with limited or no focus on the perpetrator. In this case there was evidence of meetings with Father and social workers informing him of their plans, such as to hold an ICPC and to seek legal advice and implement the PLO. The child protection conference chair also spoke to him prior to both conferences. There is a record of a new social worker ringing him in November 2021 but there followed a period of both parents effectively avoiding CSC, including not attending the initial PLO meeting. In supervision the social worker and their manager agreed that there were continued significant concerns about the parent's relationship, them not engaging in services to add safety and them not prioritising the children needs, so legal advice was sought.

4.20 From July 2021 Mother had been receiving support from a Next Link IDVA.[14] The support was largely in respect of her need to be rehoused and not for wider safety planning or support. There had been occasions during 2019, 2020, and earlier in 2021 that Next Link had offered support to Mother, but she had not engaged. When she was being supported during 2021 she was clear she was not having any contact with Father and that the children were only seeing him at their paternal grandparent's home. This support with rehousing was offered without any consideration of the dynamics of the relationship between Mother and Father, and without any expectation that Mother would engage with support in respect of domestic abuse, such as the Freedom Programme[15], as it

[14] The Next Link IDVA (Independent Domestic Violence Advisor) service is a commissioned short term intervention service. The average support time is 6 weeks.
[15] A 12 week programme for women (although it can also be used with men) who want to learn about the dynamics of domestic abuse in relationships

is recognised that safer housing is an essential part of a victim accepting further support. Mother was clear when speaking to the social workers involved at the time that she would not attend any groups, and the model available through Next Link did not include individual interventions. Considering this, CSC planned to work with both parents on healthy relationships as part of the child protection plan, and a Social Work Assistant had started this with Mother. A Family Support Worker (FSW) based at the children's centre began a programme of parenting work with the mother in February 2022 and was undertaking one-to-one sessions in the family home. The programme is bespoke to each case but is based on the Solihull Approach 'understanding your child'. The FSW was aware of the case history and the current child protection and legal processes and attended a core group. This was difficult work as the children's mother was dismissive of the programme and insisted she did not require parenting work.

4.21 The parents' lives were described as 'intertwined' and the proximity of the homes of all family members and the school in a relatively small community made it difficult for assertive traditional safety planning that focused on the children and achieved the aim of no contact between the parents. This remained the case after Mother and the children had been rehoused with support due to the domestic abuse. The new home was just minutes away from where Father was living with the paternal grandmother. The review was told that the new property had the benefit of being just in Mother's name, which is important for women who wish to escape an abusive relationship. However the family are clear that the previous property had also just been in Mother's name. There is a growing general concern about how domestic abuse is responded to, as the expectation to 'separate and isolate' does not tend to work when there are children in a family and there is co-parenting. There is also a need to recognise that domestic abuse often continues beyond separation, and that the risk can be exacerbated rather than decrease at this time. For many families, contact provides a context for domestic abuse to continue, and this needs to be considered when undertaking assessments and making plans for children. In this case the core group needed to consider how they could support the parents to make a realistic and achievable plan for child contact without parents needing to be in contact.

4.22 The National CSPR published in 2022 into the deaths of Arthur Labinjo-Hughes and Star Hobson 'Child Protection in England' found that there is a need for 'sharper specialist child protection skills and expertise', especially in relation to; 'complex risk assessment and decision making; engaging reluctant parents; understanding the daily life of children; and domestic abuse'. The report also reminds professionals that 'how things appear may not be the reality of a child's experience.' The learning identified in this case reflects this to some extent. The national CSPR panel has recently published a thematic review of multi-agency child safeguarding and domestic abuse[16]. It makes suggested recommendations that need to be considered by the SGCP alongside this review, to align any changes required, and a recommendation has been made in respect of this.

[16] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1107448/14.149_DFE_Child_safeguarding_Domestic_PB2_v4a.pdf

4.23 Maternal grandmother told the review that she had shared her escalating concerns with CSC during February and March about the children a number of times including by email, which the review later had access to. She did not feel listened to however. The maternal grandfather also shared his concern that he did not receive a response to concerns that he shared with CSC. The grandmother stressed to the review the important role that grandparents can play in safeguarding children, but that there needs to be good communication to enable this to happen. She stated that the particular insight that wider family members bring needs to be taken seriously. The review agrees. There is evidence that concerns were largely responded to, however the parent's lack of consent for information sharing was a hindrance in providing feedback to the grandparents, leaving them frustrated and concerned. A process which involves the relevant extended family in safety planning where children are on a child protection plan due to domestic abuse and where there is wider family involvement, would be beneficial. It would need to take into consideration, the family complexities, the impact on the children of domestic abuse and a pragmatic plan that the whole family can own to assist in safeguarding the children.

4.24 When they were seen individually by the social worker, both parents denied the concerns shared by their families. This included ongoing domestic abuse, unregulated behaviour, posting inappropriate and concerning content on social media and using cocaine. They also underplayed concerns that they were not able to manage the children's behaviour, that Mother physically chastised the children, and that the children were sometimes dirty and hungry. The 2022 national review that is referred to above said, in regard to Star Hobson, that 'the growing weight of concerned voices speaking on behalf of Star should have prompted professionals to reconsider the escalating risks to her.' The emails sent by Maternal Grandmother in respect of the children in family A also warranted the same consideration. They were to a degree, as the case had recently been escalated to the PLO. However Mother's avoidance of CSC over the next month (she was not available for five visits in March 2021, two of which were unannounced) means that there was no opportunity taken to discuss the concerns shared in detail.

4.25 The avoidance by Mother of the social work visits was accompanied by a complaint about the social worker having discussions with wider family members about the children. There had been a new social worker allocated in January 2021, who had to understand the history, build a relationship with the children and parents, and work to move the plan forward. There is no doubt that a new allocation at such a crucial time will have had an impact on the plan, and they told the review that they were concerned about damaging the relationship with Mother if she felt they were going behind her back to speak to her family.

4.26 There were a significant number of new professionals involved with the family at the time of the serious incident. New people had been introduced as well as a relatively new social worker for the children, including legal advisors as part of the PLO process, a family support worker and a social work assistant. The family support worker told the review that there was little time for them to build a relationship with Mother, which limited the opportunities to challenge her about the children

without her becoming defensive and avoidant. She also reflected on the perceived requirement for the work she was undertaking to be used as evidence in court, rather than to meaningfully engage with a parent in respect of their parenting.

4.27 The case was referred to the MARAC in November 2021, with Father noted as the perpetrator and mother as the victim. The review was told that the professionals involved in the MARAC locally are increasingly aware of the potential complexity of the abuse where there are reports of domestic abuse from both adults. There have been increasing numbers of reports submitted to the MARAC with indicators of violence from both partners. This is a challenge for the MARAC and for services in place to support perpetrators and victims of domestic abuse. The MARAC protocol is being reviewed to reflect this, with a plan to ensure that this issue is noted as a specific risk and that actions must be agreed to address these. They may include whether a 'who does what to who' assessment is required and completion of the Respect Toolkit. A further issue is that services for victims need to avoid a conflict of interest so will only work with one of the couples, not both. So, if it is thought there are two victims, this can be an issue, again highlighting the need to ensure that a timely assessment of the way that domestic abuse manifests in a particular relationship is prioritised.

4.28 There is evidence that the MARAC in South Gloucestershire considers any children in a robust way, and that while this may not be referred to specifically in the child in need or child protection planning, there is an expectation that the professionals working with the children are aware of the MARAC plan and that they attend MARAC meetings, which are now held using Teams[17] to enable improved attendance. It may not be realistic for all the professionals working with a child on a child protection plan to attend a MARAC meeting. This case included the involvement of a family support worker, leaving care PA, school, health visitor and others. Good practice would be that there is a plan in place to ensure that at least one representative from a core group attends and that feedback is given to the others. It is understandable that MARAC plans are not specifically referred to in a child's plan, due to the need to ensure that both the MARAC process and any plan are confidential. It is important that a victim is not put at further risk due to the perpetrator being aware of the MARAC. However, if there has been a MARAC and a plan is in place, all of those working with the children need to be aware of this.

4.29 It is only the high-risk domestic abuse cases that are considered at MARAC. The number of referrals has increased and they do not come just from the police, however the quality of referrals means that a large percentage do not meet the threshold for consideration at the MARAC. The local model now uses the Safe Lives best practice guidance[18]. When a new MARAC coordinator is in post in September 2022 (there have been staffing issues) there is a plan to ensure that even the cases which are referred but do not meet the threshold receive some guidance and consultation.

[17] Video meeting technology
[18] https://safelives.org.uk/practice-support/resources-marac-meetings

4.30 When Mother met with the lead reviewers. She said that she knew that the only option available to her was to separate from the children's father if she wanted to avoid the children being removed from her care. She reflected that this was not a realistic demand in their case, and that professional help in improving their relationship would have been a more effective way of engaging the couple and safeguarding the children. She felt that her contribution to this review should be the message that parents are likely to feel unable to ask for help and may not be honest with professionals about their relationship if they believe they will 'lose' their children.

Professionals across agencies need to have a full understanding of the parent's histories and vulnerabilities, and must consider the impact of this when they are undertaking assessments and working with families

4.31 Concerns about domestic abuse having an impact on the children were first identified when the oldest child was just three weeks old in 2017, when a third-party report was received by CSC stating that there was domestic abuse in the home. This was followed by two incidents where the police were called, including one where Mother threatened to kill herself. An Initial Child Protection Conference was held and a child in need plan was the outcome. The plan was closed three months later. Just two months later, Mother made an allegation of a physical assault from Father while she was pregnant with her second child. An assessment was completed but there was no further action from CSC. Occasional reports were received by CSC during 2019 and 2020, none of which resulted in further action, until the GP for Mother and the children made a referral to the MASH in April 2021 stating that they were concerned about the children's safety due to domestic abuse and mother's drinking. As well as domestic abuse within the relationship, there were concerns about both parents' behaviour towards the mother of another of Father's children.

4.32 There is a commitment in South Gloucestershire to all professionals being trauma aware when working with children and their families. The impact of childhood trauma and adversity when adults enter a relationship and have children of their own needs to be considered whenever there are safeguarding concerns for their child/ren. This is particularly an issue when the parents are young, as they were in Family A. Research into ACEs show that when experiencing abuse or neglect as a child, and the longer it is experienced for, the worse the physical, mental, and social outcomes are likely to be. This serious impact includes the possibility that their children will be known to safeguarding services, and that they will require support in the future with their longer-term mental health.

4.33 In this case the children's mother is a care leaver who had a history of extensive abuse and trauma as a child. She had sporadic contact with the Transition to Independence Team[19] over the timeframe of the period being considered by this review but made contact again requesting support when the children became the subjects of child protection plans in August 2021. The service has the flexibility to provide this support if a care leaver is under the age of 25, and this is good practice and responsible corporate parenting. The involvement of this team and including

[19] The South Gloucestershire team that supports care leavers

their information in any assessment was important. In Mother's case the worker who knew her well was still working in the Transitions to Independence Team and was able to support Mother but also to work together with those involved with the children, to provide background information on Mother's history and support in engaging with her. The review was told that the Child Looked After nurse can also hold important information and that they are a resource that could be consulted when a young care leaver becomes pregnant.

4.34 Father was not known to CSC as a child, but there was a contact with his GP about anger management when he was around 15.

4.35 Both parents had mental health issues. Prior to her first pregnancy Mother had taken an overdose. This was known to her GP but not shared by them or by Mother with the midwives who were involved during any of her pregnancies. The Transitions to Independence Team were also not aware of this. Mother was prescribed antidepressants on several occasions over the years following this overdose. The context around these prescriptions and mother's mental health more generally was not well known to all of the professionals working with the family in respect of the children. However, there is evidence in the health visiting records of discussions with Mother about her mental health and what support she had in place. There were also conversations recorded about the impact on the children. She told the review that she particularly suffered with anxiety after her second child was born, and that she required support. The Transitions Service provided part time nursery places for the two children at the time which she described as incredibly helpful.

4.36 During the pregnancy with her youngest child in 2020, which was during the first wave of the COVID pandemic, Mother reportedly attended the hospital maternity department 18 times reporting common pregnancy symptoms like abdominal pain and reduced fetal movements. This frequency of attendance could be considered unusual. Maternity services did not record if there had been any consideration of whether domestic abuse or her mental health were contributing factors to the numerous admissions. She was asked about domestic abuse on four of these admissions and responded that there was none.

4.37 Father also had some known vulnerabilities due to his mental health. In July 2021 paramedics are called to the home address following reports that Father had taken an overdose following an argument between the parents. The following day the police were called as there had been a domestic abuse incident and Father was arrested. There followed a strategy meeting and agreement that an ICPC was required. There was recognition that Father's overdose was potentially a sign of him being emotionally abusive, and the impact on the children was recognised.

4.38 Both parents were known to use cocaine on occasion, but this was presented to professionals as social use and was not considered by either parent to be an issue that impacted on their lifestyle or children. It was recognised that this required further assessment however and as part of the PLO process that was in place when Father died, hair strand testing for substances had been commissioned. The wider family had shared concerns early in 2022 about the extent of the cocaine use by the mother. Parental alcohol abuse was also thought to be further risk in the family, with

several references to mother's drinking. There was no evidence of any plan to assess or address this. Part of the reasons for this was that the parents were never seen to be intoxicated when visited by professionals. Mother also downplayed the issue, stating that she would only drink when she went out and used babysitters to care for the children. There had therefore been a degree of professional over optimism in respect of substance misuse and consumption of alcohol by the couple. This was largely due to domestic abuse being the main and most pressing concern throughout the period considered by this review, and the issue that was most likely to increase the risk of harm to the children.

Practice and systems need to be child centred and must consider a child's lived experience when there are dominating adult issues

4.39 As well as understanding the parent's vulnerabilities, all professionals need to be aware of the impact of this on the children, with particular regard to their lived experience. The parents' relationship included domestic abuse, substance/alcohol misuse and mental health issues, and the impact on the children needed to be considered in respect of the risks to them of these parental vulnerabilities. The importance of professionals having a child centred approach is well recognised in safeguarding work. Those who were involved in this review reflected that when working with a complex case like this, it is possible for professionals to get 'caught up in the chaos' and for the drama around the adult relationship/s to impact negatively on the required focus on the children. The rapid review meeting that considered the records for the family across agencies reflected that the information held in agency records was focused predominantly on the parents rather than the children.

4.40 Previous CSPRs and Serious Case Reviews have found that professionals can become overwhelmed by complex interactions with parents who can be avoidant, resistant, angry, and/or emotional during visits. This is particularly a risk when the children are younger and do not yet have a voice. This was the case on occasion here. The FSW who was asked to undertake parenting work with the family in February 2022, told the review that Mother was very difficult to engage with. Having missed several appointments, she came across as angry and guarded on the three occasions she met with the worker. There was a degree of understanding about this from the FSW, who recognised that her involvement came at the time of legal processes beginning, and that parenting work tends to be more successful and engagement more meaningful when they become involved earlier in the process, when concerns are emerging, and professional involvement is less pressured for the family.

4.41 The focus of the work with this family was on the adults, as it was their relationship that required assessing and a plan was made in respect of the parent's relationship in the hope that this would ensure that the children were safeguarded. There was a clear view from the professionals consulted with during this review that the children in this family were victims of domestic abuse in their own right. Consideration was given to reports by neighbours to the police and to the NSPCC stating that they regularly heard shouting and the children crying, and these were responded to.

However the allegations and counter allegations made by the parents dominated the professional contacts with them, and the period of child in need planning earlier in 2021 was not successful in safeguarding the children.

4.42 The assessment undertaken in September 2021 states that the children were observed to be 'calm and unperturbed' during specific abusive incidents between their parents and the assessing social worker recognised that this was a safeguarding concern. The child protection plans, and then the legal response show the level of professional alarm, and that the situation was being taken seriously and that there was a focus on the children. There were occasions when the social workers involved saw the older children alone. They reported an occasion where the eldest child was crying and upset, and attempts were made to find out why. It was acknowledged that the child did not really know the social worker on this occasion however, and that they had met three different social workers since the assessment was started in September 2021. The Parent Link Officer at the child's school knew the child well and attended core group meetings and was able to feedback on her regular 'check-ins' with the child. The worker remains involved and is providing support following the death Father and imprisonment of Mother.

4.43 While speaking directly to children is good practice and, in many cases, essential, it is also important to understand that children may not be able to express themselves or that they may feel conflicted and/or concerned about sharing too much about their lives or any concerns they have. After the death of the children's father, their grandmother told professionals that the children had been told by their parents not to talk to social workers and not to tell anyone when their father was at home. This would have made the children cautious and guarded with professionals and the likelihood of this needs to be considered whenever there is any contact with a child. It is also necessary and important to consider a child's behaviour and what they might be saying without words.[20] Mother told the health visitor in June 2021 that the two eldest children would fight with each other a lot and that she struggled to manage this. At the time this led to parenting advice but understanding that this was also potentially learned behaviour needed to be considered. The FSW involved in the six weeks prior to the father's death saw the children all together with mother on just one occasion. She noted that there was no physical warmth shown to the children, particularly the boys, from their mother. She also noted that they were spoken about negatively by their mother who struggled to consider their experience and needs. She felt they were children who had not been taught to manage their behaviour and who were blamed for this at home. Professionals need to ensure that they are alert to this as emotionally abusive and recognise and challenge child blaming language.

4.44 Information sharing about domestic abuse needs to be timely and detailed, particularly when there are children in the household. Information on an incident in the family home on 11 September 2021 was not received by the children's social worker until 1 October 2021. This included information that indicated that the parents remained in a relationship. This was due to the officer who attended

[20] The voice of the child: learning lessons from serious case reviews. Ofsted 2010

not tasking this on the police system as a safeguarding matter at the time, although they did so two weeks later. Avon and Somerset police have identified improvement action in respect of this specific incident, although it is acknowledged that there was timely information sharing on other occasions.

4.45 The review has found evidence of the parents not entirely cooperating with services both historically and more recently. During her pregnancies, Mother's engagement with maternity services was inconsistent. In her second pregnancy she reportedly did not engage with midwives after 28 weeks. Mother did not attend the child protection conference or respond to attempts by the chair to speak to her before each meeting. It is acknowledged however that the use of video technology for important and serious meetings with families can be extremely difficult for them. At the time the conferences and core groups were all being held on Microsoft Teams as video meetings and there are many parents who struggle to attend due to access to the technology or the anxiety about such a difficult meeting being held in this way. Mother told the review that she had to access the meetings on her telephone and that she was not always aware of what was being discussed. She also stated that it was difficult to know what meetings were being held and whether she needed to attend.

4.46 The lack of engagement alongside a professional view that the couple remained in a relationship, evidenced up by calls to the police reporting shouting from the family home in November 2021, led to a decision to seek legal advice and engage with the parents via the public law outline as a pre-proceeding intervention. There was some delay around the legal process once the decision to follow this route had been taken, due to the parents not attending meetings. There has been single agency learning in respect of this and the need to ensure that timescales are met in a way that is child focused even when parents do not engage.

4.47 There is a national focus on the need to ensure that fathers are seen as equal parents by all professionals working with a family, and that 'parent' does not mean 'mother'. In this case it was the father was more often took the children to health appointments and to nursery. However, when parental contact was attempted to talk about the children, this was almost always attempted with the mother, even by those who knew and had contact with the father. The 2022 National CSPR 'The Myth of Invisible Men' states that practice continues to reflect 'deeply engrained roles, stereotypes and expectations about men, women, and parenthood in our society' and that 'notwithstanding major social changes, women continue to be regarded as the prime and sometimes only protective carer for their children.' Research[21] by the Family Rights Group shows that professionals tend to see men in a family as either 'a risk or a resource' rather than an as equal parent who needs to be assessed, supported, and challenged along with the mother. In 2015, a report from the US by Sandstrom et al[22] made specific helpful recommendations about identifying fathers and male carers, including: 'being explicit with mothers about the importance of

[21] Family Rights Group, Fatherhood Institute, Daryl Dugdale (Bristol), Professor Brigid Featherstone (Open University) 2012
[22] Approaches to Father Engagement in Home Visiting Programmes. 2015

speaking to the father and including him in the process, while also ensuring that she would not be put at risk; speaking separately to the father rather than gathering information solely through the mother; and arranging separate home visits if necessary to explain the relevance of his involvement with the child, communicating a willingness to include him in decisions.' Those involved in the case recognised the importance of this and planned to ensure this was the case.

4.48 The nursery being attended by the middle child on a bursary place told the review that they were not made aware of the child protection plan until some weeks after the child started there. Apparently there are no systems in place for a nursery to check CSC involvement with a family if this is not disclosed by the parent, as it was not in this case. The CSC records show that the nursery was in fact contacted two weeks after the child started. The nursery are now doing face to face meetings with the parents of a new child in order to complete the form, in the hope they can gain more accurate information this way and gain consent to undertake checks with health visitors, which would be good practice.

4.49 It appears that core group meetings were held regularly at this time but there are no minutes or updated plans to show whether the parents attended, what was discussed and who was invited or informed. It is known that when individual professionals are under pressure it is often administrative tasks that are not completed, and this appears to be the case here. The review was told that there has been a recent focus on improving administration support for core groups and that meeting records are now being completed and shared.

4.50 Learning has been identified and disseminated[23] by the hospital trust following a decision made in A&E to not make contact with children's social care following the stabbing. The learning includes the importance of professional challenge to senior staff if advice is not felt to be appropriate. The review is assured that suitable actions have been taken regarding this learning.

COVID-19 is likely to have had an impact on the family and on the support provided

4.51 The national Child Safeguarding Practice Review panel published a briefing paper in 2020 that considered serious safeguarding incidents reported to them during the initial COVID-19 outbreak (March – September 2020). Their analysis shows that COVID-19 exacerbated risk due to an increase in family stressors (including an increase in domestic abuse and mental health concerns alongside less wider family support), children not being seen as regularly, school closures, and difficulties with the requirement for ensuring safe professional practice. As much of the work with this family was undertaken during the pandemic, this review has considered the impact.

4.52 While the CSC teams undertaking assessments and working in child protection still undertook face to face visits to children at home, not all services were undertaking direct work at the time due to COVID-19. This included those working with care leavers, domestic abuse support and health visiting. Mother's third pregnancy occurred during the first few months of the pandemic and all health services including Midwifery were impacted by restrictions and working within national

[23] With individual practitioners and through the formal major trauma clinical case review forum

guidance for service provision that was rapidly and frequently changing. She had requested further support from the Transition to Independence service during this pregnancy, but at the time only emergency visits were permitted. The case was closed not long after allocation due to Mother's lack of engagement. Staff reflected that they would usually go to the family home to try and engage with a young person who was not responding, but that this was not an option at the time. Mother was notoriously poor at answering or returning phone calls, and in the past visits had been more successful. There was no communication between the Transition to Independence service and the midwifery service at the time, which may have been helpful in planning how best to support Mother. Gaining consent for this could have been an issue.

4.53 The health visiting service was impacted locally during the first six months of the pandemic, with 70% of health visitors in the area redeployed into adult services. This was the local response to national guidance at the time. All contact with service users by the remaining health visitors needed to be by telephone, as they were in this case. Clinics were not held. The national panel's briefing paper noted that 'virtual visits are not always effective in assessing changing needs and risks.' Those involved in this case agreed and noted that it is impossible to establish who is in the home where domestic abuse is an issue. They also reflected that where there are concerns about how open and honest a service user is being, this is more difficult to establish during a telephone appointment.

4.54 Next Link continued with face-to-face contacts in essential situations or if the client preferred this, but largely used virtual platforms for their work from March 2020. One of the impacts of national lockdowns was the shortage of places to meet outside of the home, which is what is often required in their work. They also reflected on the impact among their service users of the fear about Covid, largely fuelled by misinformation on social media. Home visits could also lead to difficulties. With communities being vigilant about visitors to their neighbours, service users sometimes stated that they did not want visits from professionals that may lead to questions or recriminations.

4.55 As well as the lockdowns having an impact on mental health, there was also a potential financial impact for Family A, as father was self-employed. Despite this, Mother told the review that the first national lockdown was a happy time for the family, as Father was not working, was not spending time and money drinking at the pub or using drugs with friends. She was also not drinking as she was pregnant with her third child.

4.56 It is known that around 30 minutes before the serious incident that led to this review, Mother had contacted the police from a local pub saying she had been assaulted by receiving a punch to the face by a man who was not father. The man was apparently no longer at the scene. Due to operational demands and the Threat, Harm, Risk assessment[24], the police were not able to attend immediately. Mother said she did not want the police involved, would not give an address, and agreed to call back if she changed her mind. It is thought that the children were present. The

[24] Police process for decision making

police told the review that expected practice was followed in responding to this call and no learning has been identified. It is not known if this information would have been shared with CSC had the more serious incident not followed, considering the children were on a child protection plan.

5 Conclusion and recommendations

5.1 This CSPR has considered and analysed what happened in this case to identify learning that will be helpful for the wider system. It shows the importance of consistent, skilled and timely engagement with a family from professionals that know the history and understand the complex nature of domestic abuse within the particular relationship. This case has highlighted the need for professionals working with children in a case where domestic abuse features to have access to consultation with domestic abuse specialists to discuss a case and to gain an understanding of the particular dynamics that may be significant when planning for safeguarding the children, and for services to provide support and assessment for lower risk perpetrators. It has also led to a wider discussion about the need for preventative work with the most vulnerable young people before they become parents, and for services to be proactive rather than reactive in respect of domestic abuse. The Transitions Team are currently providing Freedom Programme work with a group of care leavers who they consider to be at risk of domestic abuse in the future. This is a model of prevention that should be considered more widely with particularly vulnerable children and young people.

5.2 Single agency learning has been identified during the review and recommendations have been agreed to address these, including single agency SMART action plans. There has been excellent cooperation with this review from partner agencies, which was essential in establishing the learning from this case.

5.3 Having considered the learning, the following recommendations are made with the aim of ensuring that the required improvement actions are achieved:

Recommendation 1

That the SGSCP considers the practice briefing on safeguarding children in families where there is domestic abuse that was commissioned following the National CSPR ‘Child Protection in England’. The learning from the Family A review should be considered alongside to align any changes in practice or systems that may be required.

Recommendation 2

The SGSCP to consider the learning from this review in their current review of the domestic abuse training offer. This should include the requirement for timely assessments and understanding of the nature of the abuse in each specific relationship.

Recommendation 3

That the SGSCP requests that all partner agencies review their forms and guidance to ensure that they specifically request and record the details of the GP for the children **and** all the adults in a household, and ensure that information is shared with **all** relevant GPs

Recommendation 4

The SGSCP to seek assurance from partner agencies regarding what they are doing to the promote the Domestic Abuse Act 2021 in respect of children as victims of domestic abuse

Recommendation 5

The SGSCP to consider making 'including fathers[25] as equal parents' a priority for 2023 onwards

Recommendation 6

The SGSCP to discuss the learning from this review with the South Gloucestershire Safeguarding Adult Board and the South Gloucestershire Community Safeguarding Partnership, and consideration to be given to a combined request that the relevant partner agencies commission services to provide earlier interventions with low to medium risk perpetrators of domestic abuse

Recommendation 7

That the SGSCP seeks assurance that information about orders or plans in respect of domestic abuse (e.g. MARAC and DVPOs) are shared with all professionals working with children in the family, and that the MARAC plan and any plan/s for the children reflect and compliment each other

Recommendation 8

That the SGSCP considers how it can ensure that professionals in all partner agencies are aware of the responsibilities for and services available to care leavers

[25] Or a non-birthing parent in a same sex relationship