

**MEDWAY SAFEGUARDING CHILDREN PARTNERSHIP**

**Local Child Safeguarding Practice Review (LCSPR) Isabel**

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# Introduction

## This Child Safeguarding Practice Review was commissioned by Medway Safeguarding Partnership after the death of a 3-month-old baby (known as Isabel in the report) in 2022. The cause of death is unascertained at the time of writing, but she was known to services and was subject to a child protection plan. It is thought (but not confirmed) that Isabel’s death was a tragic accident linked to an unplanned sleeping environment where drugs and alcohol were present. Significant to note, however is that both parents and Isabel tested positive for Covid-19 after the death was discovered.

## The death was notified to the Safeguarding Children Partnership in Medway and a Rapid Review meeting took place a few days later. Members felt that there was learning for the Partnership from the circumstances of this family and recommended a Child Safeguarding Practice Review. They notified the National Panel who agreed with the recommendation.

## At the time of writing, police enquiries and the coroner’s inquest were ongoing.

# Terms of Reference

## The Terms of Reference were agreed by the panel. Agencies involved with the family were asked to analyse their involvement via a brief written submission. To ensure that the review was proportionate, the period covered is the preceding year i.e., from May 2021 up to the date of the child’s death in March 2022. This covers services provided during the pregnancy and the few months of Isabel’s life. The review period is outside of the main impact of COVID -19, but the panel asked agencies to consider the residual impact of the disruption caused during this time.

## The report is based on the agencies’ submissions and a practitioner event with key staff that had worked with the family and knew them.

## In line with expectations, the family were contacted to contribute to the review. To date, they have not responded but the panel were keen that the door be left open for them to change their minds prior to publication.

## The broad areas included in the Terms of Reference that the panel agreed were the most important to look at were:

* What were the key events and relevant points/opportunities for assessment and decision making in relation to the child and family?
* How well were the needs of the child, including the developing child in utero responded to and the lived experience of the child once born?
* Were there considerations of the pre-birth assessment pathway? What would the response have looked like if concerns around drugs and alcohol use had been considered earlier?
* The needs of both parents? What was known about male figures in the family? What did father’s engagement with antenatal and post-natal services look like?
* Recognition and assessment of potential indicators of abuse, e.g., the impact of the trilogy of vulnerabilities/risk: (mental health, drugs and alcohol, domestic abuse)
* Issues that arose when the family crossed borders and moved to different local authorities
* Issues of disguised compliance
* The parents’ history including other previous involvement of either parent with adult or children’s services, the police or probation, MARAC (Multi-agency Risk Assessment Conference) for high risk domestic abuse, Housing, GP etc.
* How well did policies and procedures assist in safeguarding the unborn or preverbal/ non mobile baby including co-sleeping?
* Consideration of local multi agency and single agency policies or procedures
* Did actions accord with assessments and decisions made? Were appropriate services offered/provided or relevant enquires made, in light of assessments or presenting factors? Were records systematically reviewed to evaluate and assess risk?
* Should the lack of engagement and DNA’s (Did Not Attend) have raised concerns and have been escalated?
* During the antenatal and perinatal period particularly, how did services interact with each other when they were concerned about disguised compliance, incomplete information, or failure to engage?
* How well were parental needs assessed e.g., domestic abuse, mental health issues, substance misuse and difficulties with housing? Was interaction between services sufficient in identifying information and to support decision making needed?
* How was supervision and professional curiosity and possible disguised compliance explored in supervision? How do we support practitioners to work with uncertainty?
* Was the application of threshold appropriate given the available information e.g., what was known and knowable in the system?
* What recurring issues has this review identified for the service / multi agency? How are these being addressed within the agency?

# Summary of agencies’ contact with the family

## The agencies’ submissions as part of the review process have been co-ordinated into a combined chronology and briefly summarised here. Further information is provided in subsequent sections to add context where relevant. This is not intended to be an exhaustive list of day-to-day contacts but highlights the main interactions and highlights multi-agency activity.

## Mother was known only to universal services prior to Isabel’s birth. Mother had previous relationships where she was a victim of domestic abuse, and this was also a feature in her extended family. During the review period, she was involved with two men, one of whom was the father of the baby. Both men were well known to police and probation services due to violence and aggressive behaviour particularly against women.

## Adult A (the baby’s father) was presented to MARAC[[1]](#footnote-1) in Medway twice and assessed as a high-risk offender. He has another child he is prohibited from having any contact with, and a non-molestation order in relation to that child’s mother.

## Mother met Adult B on the internet, and he has a history of assault and battery convictions.

## **Practice Episode: May – June 2021. Mother booked her pregnancy.**

## In May 2021 Mother booked her pregnancy in Medway. At the booking appointment, she disclosed significant previous drug and alcohol use (6/7 months previously) but reported that this had stopped by the time of the booking. Screening for domestic abuse took place which Mother denied. She described her relationship with Adult A as ‘on and off’ and it was not clear at this stage what part he would play in the baby’s life.

## Due to the disclosures about potential drug and alcohol misuse, the midwife made a referral to the Medway Maternity Safeguarding Midwifery Hub[[2]](#footnote-2). The referral was not accepted as the concerns about drug use were thought to be historical. Alcohol misuse was not included in the referral and the drug use on its own was thought not to warrant inclusion for discussion at the hub. There were no major concerns in relation to the pregnancy at this point and further routine appointments were booked as the pregnancy progressed.

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| **PRACTICE LEARNING POINTs** |
| Poor engagement with and exploration of father’s and other significant males in children’s lives is a familiar theme in multi-agency case reviews. This is explored further in paragraphs 4.32-4.36The Safeguarding Medway Maternity Safeguarding Hub is an established multi agency forum where concerns about vulnerable pregnant women are discussed to plan support for them. The referral to the hub for this mother was not accepted as the concerns were not thought to warrant it. The information was, however, incomplete as information about previous excessive alcohol use was omitted. The review has highlighted a number of learning points in relation to this forum and more is said about this in paragraphs 4.5 and 4.6. |

## During July 2021, Mother DNA’d 2 antenatal appointments. These were rebooked and she did then attend a third one when it was offered. Throughout the pregnancy, lack of contact and DNAs were an ever present feature.

## **Practice Episode: August - October 2021. Domestic abuse incident with extended family**

## Mother and Adult A were staying with Mother’s extended family in August 2021. Kent police responded to a domestic incident at this address when an argument occurred between Mother’s stepfather and Adult A as stepfather did not want him staying at the property. A domestic abuse risk assessment was rated as standard but neither Mother nor Adult A were spoken to as they were not at the property when the police arrived. The informant had noted that there was a pregnant female at the home and there was another child present (Mother’s younger sibling). Information about the pregnancy was not passed to the officers dealing with the incident.

## Later in the month a further antenatal appointment was missed by Mother and in response, the midwives commenced a DNA checklist to monitor her attendance. Mother was then seen at the beginning of September.

## In September, Mother continued to be inconsistent with her attendance at antenatal appointments. She DNA’d four appointments in this month and attended three. There were no concerns noted at the appointments she did attend. Midwives were persistent in trying to engage her, even suggesting that she book closer to where she was living (Swale). She declined to do so, and the pattern continued in October. Some appointments were missed but then others were attended.

## Mother moved to temporary accommodation in October 2021.

## **NB** In September a strategy meeting was held by Medway CSC (Children’s Social Care) in relation to Adult A’s other child and a non-molestation order was granted because of Adult A’s aggressive behaviour towards his ex-partner. This activity was not linked to this family at the time because this pregnancy was unknown to social care and the police.

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| **PRACTICE LEARNING POINTs** |
| Good practice was seen in the midwives’ persistence in offering alternative appointments for Mother and the commencement of a DNA checklist to track her attendance.The review has highlighted some gaps in practice in relation to the DNA checklist, which was incomplete, nor was it clear whether the DNAs should be consecutive or non-consecutive. This is explored further in paragraphs 4.10 – 4.13 |

## **Practice Episode: November 2021 – Isabel is born.**

## On November 11th Mother DNA’d another ante-natal appointment. The baby’s birth was imminent at this point and so the midwife contacted the safeguarding team for advice. The midwife was advised to contact CSC in Medway to check for previous history, asked to explore concerns other than the DNAs, complete a maternity support form and do a home visit. The safeguarding midwives expressed concerns about possible disguised compliance and DNA’s, hence the number of tasks. The tasks were not completed – possibly due to the proximity to the birth which happened a few days later.

## Isabel was born early (36+4 weeks) in mid-November. Mother gave birth alone (i.e., no birthing partner or family members) but there were no significant concerns noted and Mother and baby were discharged home the following day. Mother was allocated further temporary accommodation, so moved again the day after being discharged. It is unclear how much time she spent there as she also spent time at her parents’ address (the address she was discharged to). The pattern of DNAs continued with midwives and subsequently the health visitor after the baby’s birth. Mother attended just enough appointments to allay professional concern. The family were placed on the health visitor’s targeted support caseload, as additional needs had been identified e.g., the baby was premature, and Mother was still in temporary accommodation. Mother was allocated 28-day care from the midwifery service.

## It is unclear how much time (if any) Mother spent with her family after the birth of the baby, but it seems that at the end of November, she transferred health visiting services from Kent (Swale where her family lived) to Medway. Despite various attempts, mother and baby were not seen by professionals between 24 November and 13 December. On the 13 December they were seen and discharged from midwifery. Again, no concerns were noted but midwives were unaware at that point that the police had responded to a domestic abuse incident on the 9 December.

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| **PRACTICE LEARNING POINT** |
| It is not completely clear why the tasks advised by the safeguarding midwifery team were not carried out. The consequence of this was that information uploaded to the system was disjointed as both the Maternity Safeguarding Support Form and the DNA checklist were incomplete. A period of sickness in the management group meant that these were not followed up by another manager. A new system is now in place to ensure that cover is available in periods of absence.Designated safeguarding professionals play a vital role in the reliability of the safeguarding system as a whole, and therefore advice given by them should be treated as a priority. This is explored further in 4.14 - 4.17 |

## **Practice Episode: December 2021 – Domestic abuse incident leads to CSC assessment.**

## On the 9 December, the police received a report that Mother had been assaulted outside her home by Adult B (picked up by MASH (Multi-Agency Safeguarding Hub) in Medway on the 13 December). This was reported as a fight between Adult A and Adult B in and outside of her flat. (Isabel would have been 4 weeks old). The MASH report details Adult A having assaulted Adult B with a knife and he had associated injuries. The immediate safety plan was that Mother and baby went to stay with her parents in Swale.

## On the 10 December, another visit by the midwifery service was DNA’d. A note was left stating the concerns about the lack of contact and that social care would be contacted if there was still no response. Mother responded to this, and mother and baby were seen on the 13th when they were discharged from midwifery.

## On the same day, CSC in Medway responded to the referral from the police regarding the domestic abuse call out on the 9th. Agency checks revealed that mother had previously been a victim of domestic abuse and there were serious concerns about Adult A and Adult B. This was allocated for a Children and Family assessment under s17.

## Mother consented to agency checks and these were completed. There was a decision to refer to MARAC by CSC, but this was not completed. There was no strategy discussion or s47 enquiries as Mother was said to be acting appropriately in going to stay with family.

## The social work assessment started just before Christmas with a home visit to mother and the baby. Mother stated that she was no longer with Adult A, but he was visiting three times per week to have contact with the baby. This was not cross referenced to his other child that he was prohibited from having contact with.

## Throughout December, Mother continued to be avoidant of professionals.

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| **PRACTICE LEARNING POINT** |
| The response to the initial domestic abuse incident did not take sufficient account of the seriousness of the incident or the coercive control element of the abuse. Mother was seen to act protectively but the decision making would have benefitted from more emphasis on the background and profile of the alleged perpetrators rather than solely on the short term protective action of Mother. Both men involved had significant histories. This is explored further in 4.32-4.37 |

## **Practice Episode; January/February 2022 – Further incidents of domestic abuse.**

## On the 1 January, Mother called the police after Adult A forced his way into the property and smashed up some of her belongings. The police responded and again Mother and Isabel went to stay with her mother. A domestic abuse risk assessment was completed by the police which was rated as medium. It is not clear what contact there was between the police and CSC but there was no formal strategy discussion. Mother and baby were assessed to be safe, and CSC continued their assessment under s17, while the police attempted to find Adult A to arrest him.

## In the early hours of the 6 February and again on the 7 February Adult A again forcibly entered Mother’s flat via a window. This incident was assessed by police as high risk, but they were unable to find Adult A to arrest him. Mother was assisted in securing the flat and police arranged for panic alarm to be fitted which was completed the same day.

## The allocated Social Worker had contact with Adult A who tried to mislead the social worker and denied having seen Mother. This was untrue. At the same time, Mother was preparing to move into a new property.

## Mother moved again two days later as she had accepted an offer of social housing. The address was close to her previous address. Mother contacted Medway Housing Services twice as it was not considered safe for her to be in Medway due to the risk from Adult A. This was responded to by Housing in the form of advice as they could not contact Mother directly. Their review of CSC’s electronic data system did not corroborate Mother’s information but there was no direct contact between Housing and CSC until the ICPC (Initial Child Protection Conference) in early March. Again, it is not clear how much time she spent at the property or if she was residing mostly at her mother’s address in Swale.

## Medway CSC had reached the end of their assessment. In response to their findings and the domestic abuse incidents, a strategy discussion took place and agreed a single agency s47. Many concerns were shared about Adult A at the meeting e.g., high risk domestic abuse, poor mental health, and drug related issues. It was also shared that Mother’s extended family were also known to services regarding domestic abuse. It was reported that Isabel was ‘not brought’ to many health appointments, including her routine immunisations and screening checks. Housing were not at the strategy meeting so the information about Mother contacting them saying that she felt unsafe was not shared.

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| **PRACTICE LEARNING POINT** |
| It was good practice to hold a strategy meeting and Initial Child Protection Conference, but this was late in the day and after several very serious domestic abuse incidents. Earlier multi agency collaboration would have revealed the concerns about Mother’s extended family, Adult A, and Adult B at an earlier point. This is discussed in greater detail in paragraphs 4.18 – 4.31. |

## **Practice Episode: March 2022 – Initial Child Protection Conference**

## In early March, an Initial Child Protection Conference was held. Isabel was made subject to a Child Protection Plan under the category of emotional abuse. The meeting was attended by CSC, police, health visitor, the GP and Housing. Mother was made aware of Adult A’s history at the conference but not Adult B’s. The Chair encouraged Mother in the use of Domestic Violence Disclosure Scheme (Clare’s Law)[[3]](#footnote-3) to enable her to keep herself and Isabel safe by understanding partners’ police histories.

## Adult A was not at the conference, but the Chair spoke to him beforehand. He denied being a risk and wanted to emphasise that he was seeking help. The plan from the ICPC was that Mother and baby would stay with extended family until the house she was moving into was made secure. This did not happen, and Mother moved into the property the same day. This was unknown to professionals at the time, as was the presence of Adult A in the flat.

## Three days after the ICPC, the circumstances in relation to this review unfolded and Isabel died on the 5 March. The cause of death was unascertained at the time of writing, but what is known is that Isabel was sleeping on a mattress with Mother, rather than in a cot. The family all tested positive for Covid-19. Mother had recently moved, and the baby’s cot had not been put together. There was evidence of drug and alcohol use in the flat which is a known risk indicator for Sudden and Unexplained Deaths in Infancy (SUDI). A police investigation into the death was launched straight away.

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| **PRACTICE LEARNING POINT** |
| Safer sleeping and the risks associated with it were discussed with Mother by the midwifery service, but a learning point has emerged about the importance of checking parents’ understanding of safe sleeping and how practitioners can assess this. This is discussed at paragraphs 4.7- 4.9 |

# Findings

## **The identification, referral and assessment of need and risks in pregnancy**

## The review has highlighted that Mother required support during her pregnancy but that this was not identified by agencies at the time. Opportunities to fully share information about Mother, her partner, and her circumstances at the initial stages of her pregnancy were missed. This would have been the optimal time for a number of services to form a network around the family and provide some early assessment and support. The following paragraphs seek to explain why this happened and extrapolate the learning for the Partnership.

## It is a familiar scenario for maternity services having to rely on information provided by Mothers at the appointment. Mechanisms in Medway’s NHS Foundation Trust (maternity services) exist to try and triangulate information and identify those who may need extra support, but several factors led to a disjointed approach.

## Mother disclosed at booking that she had used drugs and alcohol historically, but this had stopped by the time of her pregnancy. She reported using 64 units of alcohol[[4]](#footnote-4) a week prior to being pregnant and cocaine use 6/7 months prior. This is a significant amount of alcohol - approximately 4 times the recommended weekly allowance. There was no exploration of why she had been drinking at this level or and what had compelled her to stop. Mother gave very little indication of additional needs; she denied any domestic abuse when asked and stated the only service she was involved in was Housing. Mother gave misleading information about the baby’s father as although she named him, she initially said that she did not have any contact with him.

## Information from the GP would have established further concerns for Mother regarding her mental health, but the maternity notification was not responded to. Mother’s excessive drinking, albeit prior to the pregnancy would have been flagged along with concerns about anxiety and depression. The GP had referred Mother to a support service in 2020 to assist with her excessive alcohol use but the referral was closed as Mother did not respond to their invitations.

## ***There is work ongoing to try and ensure an exchange of information between maternity services and GP practices and a recommendation is made at 5.8 to try and strengthen practice.***

## **Information sharing and the Medway Maternity Safeguarding Hub**

## It is positive that the midwife raised a concern by making a referral to the Medway Maternity Safeguarding Hub, but this was made only in relation to Mother’s historical drug use. As such the referral was not accepted for discussion at the hub and was not revisited even after Mother began to miss appointments. It has not been established why the information about alcohol use was omitted from the referral, but it may have been overlooked due to a dual (paper and electronic) recording system. This is significant in this instance as discussion in a wider multi agency forum would have established the concerns about Adult A, mother’s potential drug and alcohol use and, alongside the information from Mother’s GP, this would have warranted a pre-birth assessment. It is not currently standard procedure in midwifery to contact the father’s GP and this represents a gap in current practice.

## Information gleaned as part of this review, has established learning in relation to the Maternity Safeguarding Hub and there are potential improvements to be made. The hub does not currently have specific criterion. In discussion with practitioners about this issue, the reason for this was cited as not wanting to be prescriptive about which women were referred there and there was reluctance to be too strict. In view of this, it seems incongruous that all referrals are screened with some being filtered out. This suggests that there are criterion but they are not widely shared or transparent. The screening is also done internally within midwifery so is potentially based on incomplete information. As noted, in this instance, several factors were unknown, and this led to poor decision making. Had all the information been made available, a prebirth assessment would have been indicated at an early stage in the pregnancy.

## ***Recommendations are made at 5.1 and 5.2 about making improvements to Medway Maternity Safeguarding Hub and the antenatal safeguarding pathway.***

## **Safe sleeping**

## As Mother was not identified as being vulnerable in pregnancy, it is unsurprising that the familiar risks in relation to safe sleeping were also not fully recognised. There is evidence from information provided to the review that midwives discussed safe sleeping with Mother on at least 2 occasions. They were largely in the dark, however about the additional risk factors commonly associated with families who experience SUDI e.g., co-sleeping, drug and alcohol use, poor home conditions, unstable housing situation, smoking and domestic abuse. Neither health visitor was able to see Mother face to face as she did not respond to the invitations, so they were not able to assess the baby’s sleeping arrangements. Although safe sleeping was discussed, the recordings were not clear about how that message was delivered and we also know that Father was not included in those discussions. The recording is important as the ‘tick box’ doesn’t give a sense of parental understanding or whether parents are receptive to what they were being told.

## The report produced by the National Panel [[5]](#footnote-5) published in 2020, emphasised the need for a nuanced approach to educating families about safe sleeping arrangements. The study recognised that for some families whose circumstances were unstable for a variety of reasons, messages about acceptable sleeping arrangements were hard to for them to hear. In this instance, it was difficult for practitioners to assess Mother’s understanding of the information partly because she was avoidant of appointments but also, she was rarely seen at any one of her homes. Mother moved three times during the review period and spent time with her family, therefore optimum opportunities to give practical advice rarely presented themselves. It may be significant that Mother had recently moved and was in the very early stages of unpacking her belongings when the death occurred as the cot had not been assembled.

## Similar issues around safer sleeping are features in other practice reviews in Kent - a neighbouring borough with many joint services. As such, work is currently being undertaken between Kent and Medway Child Death Overview Panel (CDOP) to try and improve this area of practice.

## ***A recommendation is made at 5.4 about improvements to practice in relation to safe sleeping.***

## **Dealing with DNAs in maternity services**

## A feature of this review was the number of health appointments Mother missed both prior to and post the baby’s birth. There is a general recognition that poor engagement with antenatal services poses a potential risk to the health and wellbeing of mothers and their babies. Processes are in place i.e., the DNA checklist which is designed to monitor attendance and plan support accordingly. The review has highlighted the chance to strengthen practice in relation to this.

## Poor attendance at appointments was a concern throughout the pregnancy and the DNA checklist was commenced in a timely way. Two contacts were made between the community midwives and Maternity Safeguarding. One was in August, where the midwife was asked to monitor the situation and a later one just prior to the baby’s birth in November. Several appointments were missed in September and October, but it was not until the baby’s birth was imminent that the midwife sought further advice from safeguarding colleagues. This left very little time for any proactive planning and an earlier response to the poor attendance would have been beneficial. This may have created an opportunity to identify Mother’s needs in a timelier manner.

## Mother’s appointment keeping did not follow a particular pattern, though she did respond if midwives said that they were concerned. On at least one occasion, the midwife told Mother that she would need to contact social care if she was unable to reach her and she (Mother) responded swiftly. After seeking advice, the safeguarding midwives expressed concern about possible disguised compliance and advised various tasks to try and gain more information. One of these was to contact social care to check for previous history on both Mother and Adult A. At the practitioner event it was raised that this is sometimes done informally. The tasks were not carried out, possibly due to the proximity to the birth, but this was another missed opportunity to gather valuable information.

## Early learning from the rapid review and confirmed by practitioners in this case highlighted gaps in the current DNA policy. Practitioners felt that there was no clarity about the checklist and whether the DNAs needed to be consecutive or three overall in the pregnancy. As a consequence of learning from review, this has now been modified to the expectation that the checklist commences as soon as there are three DNAs in total, rather than consecutively. DNA’s also need to be considered in the context of other risk variables such as drug and alcohol misuse.

## ***There is no recommendation in relation to this learning as the issue has been rectified since the rapid review.***

## **Safeguarding Supervision**

## Mother often cancelled appointments at the last minute and then rebooked them. When she did attend, there were no obvious concerns and Mother was able to keep professionals at bay. Practitioners who took part in the review, reported that they had been worried about Mother and the number of DNAs, they were put off taking it to formal supervision because of the lack of concerns when they were able to see her. Involvement of the specialist midwives happened at a very late stage.

## The use of safeguarding expertise in an organisation is key to the safeguarding system as a whole and was underutilised in this case. A chance to discuss Mother’s presentation in supervision with a safeguarding advisor would have provided an opportunity to explore avenues to gather information about both parents. This would also have provided clarity about what actions to take and who to contact. For example, supervision may have provided some managerial oversight and ensured that key tasks such as consulting the GP (as per guidance in the DNA checklist) and completing the Maternity Support Form were prioritised.

## There was a similar pattern of DNAs with the health visiting service after Isabel was born and she was never seen by a health visitor. This was partly due to her moving between Medway and Kent, but she also (as previously) made appointments that she did not keep.

## Changes to the supervision arrangements in Medway NHS Foundation Trust are looking to strengthen the supervision offered to designated professionals and practitioners. This coupled with changes to the DNA policy will provoke more curiosity and open more avenues for discussion in circumstances such as these.

## ***A recommendation is made at 5.7 about improvements to practice in relation to safeguarding supervision.***

## **Multi-agency response to, and assessment of, domestic abuse**

## The review has established that insufficient information was known to midwifery about Mother and Adult A. Enough information existed in the system to have warranted a referral to Children’s Social Care in Medway and pre-birth assessment, given Adult A’s previous history. The information provided by Medway NHS Foundation Trust makes the point well that there was a lack of professional curiosity about Mother’s history, her drug and alcohol use, as well as details about Adult A and the part he would potentially play in the baby’s life.

## Isabel would have been 4 weeks old when a fight broke out between Adult A and Adult B at the home address. The police were called and made the referral to MASH in Medway. The informer reported that Mother was physically grabbed by Adult B, and he was shouting at her aggressively. She was carrying the baby when police spoke to her, but she denied that either of them had been involved in the incident and neither of them were hurt.

## The notification was slow to reach MASH due the timings but was then triaged and sent straight to a long-term team for assessment under s17. This was an unusual occurrence in Medway and happened because the referral and assessment service had stopped taking work for a short period of time, due to excessive workloads. Being responsible for the initial response was therefore unfamiliar to this team, who ordinarily would take on a family after the assessment period, when risk had been assessed and an initial plan put in place. Further, the decision to assess under s17 rather than s47, was made at the front door and not re-evaluated by the receiving team.

## The subsequent response was slow to get off the ground, initially with the delay in the police report reaching CSC, but then a visit to the family did not take place until December 17 (8 days after the incident) where no access was gained. Isabel was not seen until three days after this – eleven days after the original incident. Given the history of the two men involved contact should have been made sooner.

## The initial evaluation by CSC was optimistic and possibly based on Mother minimising the concerns and her willingness to go and stay elsewhere. A more robust response would have included a multi-agency strategy meeting with a view to s47 enquiries to assess the risk to Isabel from all three adults present at the incident. Adult A was known as a high-risk domestic abuse offender and Adult B had a very significant past with Probation Services. Mother was vulnerable to violent relationships and known to meet men on the internet. Isabel was a very young baby. The lack of an urgent response may have also reinforced Mother’s view that the incident was not considered to be very serious. It shows a lack of insight into the history and dangerousness of the two men and the nature of domestic abuse where coercive controlling behaviour is a feature of the relationship.

## The grading of risk assessments of individual incidents from the police was inconsistent. Work has been done to try and strengthen their response and information sharing. Incidents in relation to Adult A were graded standard, medium, and high. Kent Police Policy changed in 2020 where there was no longer a requirement to send an automatic referral/Domestic Abuse Notification (DAN) in medium and standard risk domestic abuse incidents. It became policy that only high risk incidents were automatically sent to MASH. This caused issues with risk assessments in MASH and the policy has now changed so that decisions are made on a case by case basis by a select few specialist officers.

## When Mother and Isabel were seen by the social worker, Mother said Adult A was visiting at least three times a week to have contact with Isabel and sometimes sleeping on the sofa. The social worker accepted this, despite knowing that he was not allowed to have contact with his older child. This was also significant information and should have triggered a strategy discussion. Adult A was homeless as this point which was the reason Mother cited for not pursuing a non-molestation order, so it seems implausible that he was only there for part of the week. When Adult A was challenged by the social worker, he denied any contact with Mother which was not true.

## Police responded to three further domestic abuse incidents in January and February and referrals were made to CSC. None of these triggered a strategy meeting to discuss a safety plan or a specialist domestic abuse risk assessment. The reason for this seems to be a perception that Mother had ‘acted appropriately’ by contacting the police. On at least two occasions she had gone to stay at her mother’s house. These were serious incidents which involved Adult A forcing his way into the home, being violent towards Mother and smashing up some of her property. Throughout this period Mother complained on several occasions that Adult A was constantly contacting her and turning up at her house unwanted.

## Whilst Mother was (on some occasions) taking protective action, she was in a very high-risk situation which was unlikely to be resolved without longer term intervention being more focused on Adult A and his behaviour. There was no referral to MARAC and no early attempts to involve an Independent Domestic Violence Advocate (IDVA), though this did later form part of the child protection plan.

## Research[[6]](#footnote-6) about controlling and coercive relationships tells us that the risk to women and children increases in certain circumstances. These include during pregnancy and having a child, when ending a relationship, contacting the police and other services and when considering a non-molestation order. Mother was experiencing all of these. Further, the assessment that *she* was ‘acting appropriately’ did not consider Adult A’s behaviour pattern and his likely need to exert control as she attempted to separate. We also know that perpetrators of domestic abuse often use the pretext of contact with their children to continue the abuse. This is recognised in The Domestic Abuse Act 2021 which acknowledges that separated women are at particularly high risk and so therefore are their children.[[7]](#footnote-7)

## It was not until the end of the s17 assessment period that a strategy meeting was held which led to s47 enquiries and subsequently to the Initial Child Protection Conference (ICPC). At the strategy meeting police revealed domestic abuse in Mother’s extended family which had previously been considered as a safe haven for her and Isabel. Whilst this was unknown information, Mother and Isabel had stayed there for extended periods.

## The lack of strategy meetings and formal child protection enquiries was not challenged by any agency. Management oversight was frequent but did not alter the trajectory of the case or escalate to child protection at an earlier point. This suggests a training need, some focused practice development and a more strategic approach to domestic abuse which supports frontline practice is needed.

## It is not clear how the incidents and escalating risks were communicated to the health visitor or Housing so that they too could be vigilant about the risks posed and contribute to a safety plan. There is no evidence of network meetings to draw together a more formal plan prior to the ICPC.

## Safeguarding work is extremely challenging and complex. This scenario was complex due to a multi-factorial problem, combined with complete and inaccurate information which increased the likelihood of poor decision making. The cumulative risk was not analysed early enough with the benefits of the right expertise in each individual service to monitor, supervise and review.

## ***Recommendations about improvements to multi agency Domestic Abuse work are made at 5.5 and 5.6.***

## **Consideration and involvement of fathers/males in multi-agency work**

## Involvement of fathers and significant males in assessments is a familiar theme in multi-agency reviews. Maternity services involved with Mother did not show sufficient professional curiosity about who the father of the baby was, nor did they explore with Mother what role the baby’s father would play in their lives.

## Whilst the social work assessment and the child protection plan acknowledged the risks posed by Adult A, the emphasis on keeping Isabel safe was weighted towards Mother and her extended family. The assessment lacked an analysis of Mother’s vulnerabilities and how domestic abuse in her extended family may have shaped her views about relationships. The plan would have benefitted from being more specific about what contribution (or not) Adult A could make towards keeping Isabel safe e.g., co-operating with the police, ensuring that he did not contact Mother, and addressing his violent behaviour. These things are implicit but not explicit. Tasks for fathers and significant males in children’s lives should be prioritised within multi agency plans and assessments should be explicit about the source of the risk, especially where they pose a major risk as was the case here.

## Insufficient weight was attached to the significance of Adult A’s history and his persistent violent behaviour towards Mother. Risks escalated without robust response and there was a lack of formal assessment of him as a father, despite there being a full history to draw on. Further, information about Adult B was not shared at the ICPC and the risks that he posed were not considered, even though Mother had said that he was her current partner.

## Research tells us that the focus of multi-agency engagement in cases where domestic abuse is an issue is often the mother. This is problematic as they are often left with responsibility for controlling the abusers’ behaviours which they are unable to do. It is important to avoid the pattern of too readily accepting explanations from families e.g., where parents claim to have separated and thereby assuming mothers and children’s safety. The emphasis needs to shift to a more inclusive framework that attempts to address the risk from perpetrators by providing a range of interventions to both the abusing and non-abusing parents.

## Adult A also told the Chair of the ICPC about his attention deficit hyperactivity disorder (ADHD). ADHD is a static neurological condition, the core symptoms of which are short attention span, excessive activity, anxiety and impulsiveness which can be cause for concern if not managed. Historically, Adult A had sought help with this; some provision in the plan to support his intentions to address it may have also been useful.

## ***A recommendation is made at 5.3 about improvements to multi agency working with significant males in families.***

# Recommendations

## The Medway Safeguarding Children Partnership to request a review of improved arrangements for the antenatal pathway and satisfy itself that the referral system is working in a way that.

## Identifies the most concerning families of unborn babies.

## Refers them to relevant services in a timely way.

## All information is accessible and recorded in one place to ensure consistency of information sharing.

## In line with the above, Medway Safeguarding Partnership should oversee a review of Medway Maternity Safeguarding Hub to establish clear terms of reference, criterion, and governance.

## The Medway Safeguarding Children Partnership should reassure itself that all partner agencies have robust systems in place to ensure that fathers and other significant males are actively considered in assessments and ongoing work with families.

## The Medway Safeguarding Children Partnership and Kent and Medway Child Death Overview Panel (CDOP) to oversee a review of current practices about how safe sleeping messages are delivered and develop a strategy to promote and raise public and practitioner awareness of the need to deliver safe sleeping advice.

## Medway Safeguarding Children Partnership to oversee an audit of multi-agency practice in relation to domestic abuse at the front door. The audit should focus on threshold, multi-agency information sharing, involvement and assessment of perpetrators, decision making, consent, use of specialist services and outcomes.

## Medway Safeguarding Children Partnership to develop (or review if one exists), a multi agency strategy detailing a robust response to families where domestic abuse and coercive control are present. The strategy needs to be overarching and provide a range of multi-agency interventions to children affected by domestic abuse, as well as the abusing and non-abusing parents.

## Medway Safeguarding Children’s Partnership should oversee partner agencies’ reviews of their existing supervision practices and seek assurances that agencies have robust managerial oversight of actions, decisions, and plans in relation to children and unborn babies where there are safeguarding concerns. This should include the exploration of a range of supervision practices such as external supervision and group supervision.

## Medway Foundation Trust and Kent and Medway Integrated Care Board should continue their work on ensuring robust liaison between Midwifery services and GPs for pregnant women. This should include reviewing and modifying current systems to ensure that there is an exchange of information (I.e., two-way communication) about both parents (and partners) during pregnancy.

## Jane Doherty

## Independent Social Work Consultant

## July 2023

1. Multi Agency Risk Assessment Conference (MARAC) is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists.   [↑](#footnote-ref-1)
2. The Safeguarding Midwifery Hub in Medway and Kent is an established multi agency forum where concerns about vulnerable pregnant women are discussed to plan support for them. [↑](#footnote-ref-2)
3. The Domestic Violence Disclosure Scheme (DVDS), also known as “Clare’s Law” enables the police to disclose information to a victim or potential victim of domestic abuse about their partner’s or ex-partner’s previous abusive or violent offending. [↑](#footnote-ref-3)
4. 64 units of alcohol is approximately 4 x times the recommended weekly limit. [↑](#footnote-ref-4)
5. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\_data/file/901091/DfE\_Death\_in\_infancy\_review.pdf [↑](#footnote-ref-5)
6. In control: Dangerous Relationships and How They End in Murder Jane Monkton Smith 2021 [↑](#footnote-ref-6)
7. The Domestic Abuse Act 2021 came into effect in 2022. [↑](#footnote-ref-7)