A LOCAL CHILD SAFEGUARDING PRACTICE REVIEW
SIGNIFICANT PHYSICAL ABUSE IN CHILDREN UNDER 1 – A THEMATIC OVERVIEW

Introduction

In March 2019, Child A, who was 9 months old at the time, was admitted to hospital having been brought into the Emergency Department by ambulance with her mother. She was dehydrated with a fluctuating level of consciousness. She was found to have extensive injuries on both sides of her head, abdomen, back and lower limbs. A skull x-ray revealed a skull fracture and a subsequent skeletal survey found evidence of healed fractures to her ribs. Father was arrested for causing ABH to Child A.

Mother, Father and Child B (22 month old sibling to Child A) were known to children's social care prior to Child A's birth. Child B had been referred to social care by midwifery as an unborn baby due to concerns about domestic abuse, including controlling behaviour, and Father's alcohol misuse. Mother told the health visitor that if he (Father) found out about the referral he "would kill her". Father had a significant criminal history and was well known to probation services.

Child A is now in foster care along with her sibling, under Section 20. Care proceedings have been initiated and the police investigation is on-going. She appears to have recovered well from the injuries sustained and is not expected to have long term impairment to her health or development as a result.

This case was considered against the criteria set out in Working Together 2018 covering completion of local child safeguarding practice reviews (LCSPR). The Rapid Review Panel agreed that there was evidence of abuse and that Child A had been seriously harmed. The decision was taken not to commission an individual LCSPR. This is the fourth rapid review undertaken by Wiltshire in relation to under 1s who have sustained non-accidental injuries in the last 8 months. In addition, we are contributing to another case of an under 1yr led by another authority. Therefore, the panel concluded that learning from this case was best considered as part of a broader thematic review of the five cases.

The National Child Safeguarding Practice Review Panel endorsed this approach.

Terms of Reference

1. To pull together all the knowledge gleaned from the various relevant Wiltshire Serious Case Reviews (SCRs) and Rapid Reviews.
2. To pull together what is known from research and other developments nationally. We are not alone in facing these issues and it will be important that we take account of learning from elsewhere both nationally (through, for example, the 2011-14 Triennial Review[1] and the as yet unpublished 2014-17 Triennial Review and Research in Practice[2]) and regionally through the work underway in the south west led by Gloucestershire.
3. To identify what is already happening across the local system and where we can evidence progress in addressing the key issues.

[1] Pathways to harm, pathways to protection: a triennial analysis of serious case reviews, 2011 to 2014

[2] Research in Practice is an organisation that supports evidence-informed practice with children and families

This report is divided into two key sections. Firstly, what do we know both nationally and locally about the prevalence, risk factors and circumstances of children under 1 year who suffer significant or fatal physical injuries. This is a relatively short section – the risks to these children have been well documented in the past and from both national sources and from our local experiences there are no factors emerging that are not already well-known to the safeguarding system.

Secondly, and this is a somewhat longer section, what are the system and practice challenges and required responses to those children and their families; and what improvements and changes are required if we can be more confident that we have collectively worked together to minimise those risk factors and reduced harm to babies.

Section1: What Do We Know

National and Local Data

From the 2011-14 Triennial Review, 41% of all SCRs involved a child under 1 and under 1s had the highest level of fatalities. In the forthcoming 2014-17 Triennial Review the picture is much the same - 42% of all SCRs where the child died were under 1yrs old and of those 82% were under 6 months. Just less than half relate to girls. Very often, for children who do survive, they face life-changing injuries and significant brain damage. Children under 1 yr. will tend to have the more serious injuries and a threefold mortality rate (as quoted in Sidebotham, Atkins and Hutton 'Changes in Violent Child Deaths in England and Wales 1974-2008' which showed children under 1yrs were three times more likely to die than those aged 1-14yr).

From my membership of the National Child Safeguarding Practice Review Panel, I am aware that in addition a significant number of children under 1yr are injured but those injuries are not considered serious enough to warrant an SCR or formal referral. It is reasonable to assume that it is only luck that differentiates those children from those who are more seriously injured or killed. The numbers involved in harm caused by physical abuse therefore are likely to be higher than quoted in the Triennial Review.

Information gathered by Gloucestershire Public Health highlights several important facts. The peak age of abusive head injury for children under 1 is 3.6 months, which coincides with their peak crying period. This is not proven as a causal relationship but clearly there is a connection worthy of note. Gloucestershire also identified that they are more likely to arrive at Accident and Emergency Departments by non-ambulance and there is an average of 8 hours delay between injury and presentation (as opposed to 1.8 hrs ordinarily).

In Wiltshire, since March 2014, 54% of all cases referred to the SCR Sub Group have related to injuries to and one death of children under 1yr. In that time, we have completed 3 SCRs and 5 Rapid Reviews related to this group. We are also currently contributing to an SCR led by another LSCB in relation to injuries to a child under 1.

Local data, below, illustrates the number of children under 1 in the social care system in Wiltshire.

Data as at 31 March 2019			
	Under 1	**All**	**<1 as % of all**
Children looked after	28	468	6%
Child in need	102	2096	5%
Single Assessment	543	4842	11%
S47 completed	119	1246	10%
Child Protection Plan - total	52 (includes 20 unborn babies)	406	13%
CPP Category of abuse -Neglect	*36*	*203*	*18%*
CPP Category of abuse Physical Abuse	*5*	*45*	*11%*
CPP Category of abuse Emotional Abuse	*10*	*130*	*8%*
CPP Category of abuse Sexual Abuse	*1*	*28*	*4%*

Circumstances of Parents/Carers

The single biggest identified factor noted by the Triennial Review within SCRs is the mental health of the mother. In Wiltshire, all the recent SCRs have identified mother's mental health as a factor. Substance misuse and domestic abuse remain core issues and often they coincide: they were present in 3 out of the 5 recent local Rapid Reviews. Whilst the term 'toxic trio' is properly no longer in use, the interplay and coexistence between these issues need to remain uppermost in the minds of service commissioners and practitioners. In particular, the need to get beneath the surface in working with families remains a constant practice theme.

Again, from the Triennial Review, nationally in 30% of SCRs parents (usually fathers) have a record of violent crime: 70% of *known* perpetrators are male (it is often not possible to identify the abuser if both claim innocence). However, there is very little evidence of mothers' being the perpetrators of the physical abuse.

Parents are often young (under 21) and have had difficult childhoods – some will have been subject to children in need and/or child protection plans and some will have had periods in care. Others, although not always well explored in reviews, will have had exposure to what are known as 'adverse childhood experiences' (ACEs) or experienced trauma as children especially through loss and bereavement.

These are families who have either not engaged with or not be known to early help services and rarely have they followed a path of early help-children in need- child protection planning. Generally, the Triennial Reviews have concluded that children outside of the child protection system are more at risk of serious abuse or death than those within it and in Wiltshire, 3 of the 5 recent reviews were not known at point of incident to the social care system (although only 1 had never had any contact at all). Locally there is concern that cases are not subject to comprehensive early help assessments and can be closed too soon before real progress can be evidenced.

Poverty and deprivation are often features although rarely separately identified in reviews or research. Equally, it is not clear the extent to which poverty and deprivation are addressed as key features by practitioners. In addition, and even when this has not directly featured in recent reviews, in Wiltshire there is the added factor of rural poverty and isolation. The ability to access services, especially those which are traditionally office-based, the paucity of public transport links, the support that might be available in local networks, the protection offered by neighbours - these

and more are added features in a county like Wiltshire and which need to be separately and explicitly addressed in the commissioning and configuration of services.

Section 2: Challenges and Responses

Early Help

One of the workstreams within the Wiltshire Families and Children Transformation Programme (FACT)[3] is focussed on 'Best Start in Life' where many of the issues set out in this review should be addressed. In particular, the support currently being considered to offer parents facing baby sleeping difficulties, given the links earlier set out with peak ages of abuse.

More generally, these are cases which have been, or should have been, managed through early help provision. This raises key questions about identification, management and response to risk factors. Without developing an actuarial risk matrix, if we know young parents, those with poor experience of family life, those who have had criminal records for violence, those where mental health, domestic abuse, substance misuse are prevalent, where poverty and deprivation are features and where there is little extended family or community support are all relevant risk factors, is our early help system geared up to recognise those factors and respond accordingly?

Key Questions 1:

a) Does the early support system recognise and prioritise those most at risk?
b) Is there sufficient evidence that all agencies are contributing as needed to the early help system?
c) Is the Support and Safeguarding model appropriately responding to the various practice issues raised by this report?
d) Are those engaged in early support provision helped to manage the anxiety and risk associated with this group of families – especially the men?
e) How is the 'Best Start in Life' workstream addressing some of these issues?

Adult Risk – Identification and Response

Unlike in managing adolescent risk when the threat might come from other young people, it is a matter of fact that it is adults who represent the risk to children under 1yr. Some of those parents, or those in parenting roles, either need or are in receipt of services in their own right. When that is the case, there is evidence that there is often insufficient linkage between children's and adults' services and this raises some key questions and challenges as set out below.

For adult services, there is a series of questions about those that are and are not in receipt of services and those who have or have not been defined as having care and support needs. The Care Act 2014 states that within the duty to promote an individual's well-being, there is a specific inclusion of the duty to promote domestic, family and personal relationships. Further, it goes on to say that a Local Authority must have regard to the need to protect people from abuse and neglect. However, eligibility criteria and prioritisation of limited funds does mean that adults with lower level mental health needs (for example, personality disorder or depression or anger management and lack of impulse control) or less serious substance misuse issues will not receive a service from adult social care. However, those are often the very factors that can present serious risks to children

[3] FACT is a Wiltshire programme aiming to streamline and improve the effectiveness of how services in Wiltshire help children and families achieve good outcomes http://www.wiltshire.gov.uk/children-young-people-fact

and often warrant statutory intervention – in other words, they trigger children's services priority responses.

Put simply, adults who present the lowest level of needs to adult provision present the highest level of need to children's services and represent an enormous financial and service demand on the system as a whole – not to say on the children affected.

Adverse Childhood Experiences (ACEs)
The concept of ACEs was developed in the USA and refers to the research on the prevalence and consequences of adverse childhood experiences and identifies a number (10) of key adverse experiences in childhood that can have a significant impact on later life-chances and health outcomes. They have gained some traction in this country. It is important that people's backgrounds are properly explored and understood and links to current behaviour made. Relationship-based practice requires an exploration of and understanding of parental histories and experiences and too many reviews, both locally and nationally evidence a lack of that exploration. Equally, adult facing services need to understand mental health or substance misuse issues in terms of the history of the adults concerned and respond accordingly.

However, there is a need to proceed with some caution. There is an increasing body of research and academic papers which set out concerns with and an over reliance on a deterministic approach to ACEs. For example, "A Critique of the Adverse Childhood Experiences Framework in Epidemiology and Public Health: Uses and Misuses" by Michelle Kelly-Irving* and Cyrille Delpierre; Edwards et al (2017) 'The problem with 'ACEs': EY10039: Submission to the House of Commons Science and Technology Select Committee Inquiry into the evidence-base for early years intervention'.

Trauma-informed Practice is a related and practical approach to an understanding of ACEs. It requires practitioners to recognise the prevalence of early trauma and view current problems as maladaptive coping strategies. It incorporates core values of safety, trust, collaboration, choice, and empowerment underpinning the practice relationship between worker and parent. Recent reviews in Wiltshire have evidenced a lack of exploration of parents' histories. For example, in one case the initial referral to the Children's Centre stated that they had not had positive experiences of parenting and would need support. There is no evidence that this was explored by any agency, for example to understand the reasons for Father's alcohol misuse. In addition, the professional group did not demonstrate an understanding of addiction and the motivation or ability to change and risk trajectory related to this.

Experience is that often parents who are young and who have not had a positive experience of family life can present a greater risk than others. In particular, a number of them will have had some experience of the care system. Finally, some of the parents, especially the fathers/male carers may have had a criminal history and are known to the Police, Probation Services or the Prison Service.

These are not just key areas of challenges for adult services – they are equally so for children's services. In Wiltshire, for example, we have seen too much evidence of practitioner reliance on self-reporting of substance misuse treatment and progress. In addition, the behavioural impacts of addictive behaviour, the links with apparent 'disguised compliance', the ability to be convincing and to minimise impact of substance usage appears, from the reviews at least, to be not fully or thoroughly understood.

In addition to the issues already set out, recent reviews in Wiltshire have highlighted the challenges of working cross border with neighbouring/other authorities and how this can impact on assessment, service provision, communication and information sharing. Again, these are not new challenges but are of particular relevance for under 1yrs. to ensure the quality of care is properly understood.

Two of the reviews were on babies who were born prematurely, underwent surgery after birth and required significant time in hospital. In one case this meant that the baby remained in hospital for 3 months post birth in a hospital in another county. Understanding our ability to be alert to the potential impact of this separation on attachment and assess its importance, particularly where the birth has resulted in health complications for Mother as well, is key. Fathers' attachment should also be considered more explicitly than recent cases suggest is happening and the broader invisibility of fathers in our work with families is discussed further in this report.

Key Questions 2:

a) Is it possible to devise a whole family eligibility and priority criteria across children's and adult services?
b) Are we confident that the practice and operational linkages and joint working between children's services and adult facing services is as good as they can be and need to be?
c) Are we confident that adult services know which of their service users are parents?
d) Are they alert to the potential risk they present to the children in their care?
e) Have they got a position balancing adult right to privacy and safety of the child?
f) Do they understand the needs of those adults in terms of their histories of trauma and adverse experiences?
g) Are the Police, the judicial system and NPS fully aware of how that history might impact on their ability to be safe carers and is the working relationships with children's safeguarding services robust enough? Are there identification and reporting systems in place on which we can be confident?
h) Are the likely and predictable impacts of substance misuse or mental health or learning disability well enough understood by the children's workforce to enable them to fully assess and involve themselves with adults where these factors exist? For example, is the nature of addictive behaviour properly understood and how it might influence child care and engagement with professionals? How are managers and service leaders assured on these matters?
i) For those that have had a history of care, to what extent is the care system preparing them for adulthood and supporting them in that role once children are born – especially as it relates to fathers? Does the corporate parenting in the County and the work of those involved (i.e. not just children's social care) address the role of care leavers as future parents?
j) Are our services set up to meet the needs of families with premature babies or other health conditions?
k) Are we alerted to the potential impact on attachment for parents where there is premature birth, babies with health or additional needs and additional health needs of the mother? Is this informing assessment and how we work with families and new parents? Is this considered as part of the perinatal mental health pathway?

Professional Curiosity and Disguised Compliance

These concepts are often quoted as key features in SCRs, again both locally and nationally. It is increasingly accepted that the most effective safeguarding work is delivered via 'relationship-based practice'. This may take many forms and use many different tools, for example signs of safety, motivational interviewing or systemic thinking. However, at the heart is a relatively simple notion that the core purpose of our front-line practitioners is to be able to develop significant and authentic relationships with those with whom they are working and then be able to use those relationships to help drive change and improve safety for those at risk. If that is accepted, then it follows that to do that effectively, being curious and asking the second question is what we expect of all our practitioners. Labelling that as 'professional curiosity' can have the (unintended) consequence of separating it out as a specific and separate task or skill rather than being the job itself.

Disguised compliance implies a deviousness on behalf of families which might hinder the forming of those effective relationships. Accepting that, some families will have an experience of the state and of welfare agencies as not being helpful to them, having a fear (often legitimate) that their children might be removed, that they might start from a position of mistrust of practitioners – these are part of the conditions within which those working relationships must be built. Labelling that often understandable reaction as 'disguised compliance' is not always helpful – better to think of it as part of the challenge of forming and sustaining effective relationships with families that can be used to drive change.

Invisible and Unassessed Fathers

In Wiltshire, as nationally, we are faced with the somewhat contradictory position where those who cause the most harm are also those who are the least engaged, understood, confronted or worked with. Overwhelmingly, it is men who commit the violence to babies and it is men who are nearly always absent from the work and from service provision. Fathers are often seen in a completely binary way - either good, supportive and caring or bad, a threat and a risk and to be avoided. Typically, we do not develop rounded balanced assessments of them and their histories, their abilities and willingness to be a good parent, their challenges, support networks like we would more normally do with mothers. Work with fathers, or the lack of it, comes up in SCR after SCR.

Domestic Abuse and Coercive Control

Working with men/fathers inevitably relates to working where domestic abuse and especially coercive control is a central factor. SCRs both nationally and locally expose a continuing gap in the extent to which domestic abuse is properly and comprehensively understood. In particular, an unacceptably low understanding of the extent to which it routinely takes away options and power for the mother and impacts on her ability to care for and protect her children.

Reports continue to evidence a 'mother-blaming' approach, talk about 'a relationship characterised by domestic abuse' (rather than he was abusive, she was a victim of abuse). Domestic abuse is still too frequently mislabelled in child protection conferences as 'emotional abuse'. Equally, the system can get side-tracked with concerns about women who might abuse or relationships that are characterised by abuse on both sides. Without doubt, both things can be true – but the vast majority of domestic abuse is perpetrated by men against women. Language is important. If we describe risks accurately and explicitly, response and practice can be better and more accurately targeted. The correlation between violent adults and potential violence to children is not being routinely considered.

Key Questions 3:

a) Is our systemic response to DA specifically addressing these issues?
b) In all the practice development work indicated in this report, is there and can there be a specific gender specific based approach developed?
c) Is the fear of working directly with these men acknowledged and addressed?

Communication and Information Sharing

This remains a stubborn presence in nearly all reviews, both locally and nationally. Issues of data sharing and confidentiality have been well-rehearsed and need not be reiterated here; the 'golden rules' on information sharing are easily accessible and should be recirculated to all and should be routinely recirculated to all agencies on an annual basis.

The more specific issues that have come up in local reviews has been the reliance on the self-reporting of parents/carers by nearly all front-line agencies. There is too little evidence of any agency contacting either adult mental health services, the GP or adult substance misuse services to confirm the accuracy of what parents were reporting, or of these agencies proactively sharing this information with others. This resulted in the professional group unknowingly colluding with the story that parents were presenting rather than understanding the risks children were being exposed to.

Key Questions 4:

a) Are there any barriers to practitioners exploring and validating information given by parents about their work with or progress in treatment programmes? If so, can they be identified and addressed?
b) Are those adult agencies proactively talking to children's services issues to do with non-attendance or non-engagement in treatment programmes? If not, why not?
c) Are adult agencies actively helping children's services to understand addictive behaviour or various types of mental health and how it might impact on parenting, or their engagement with children's services?

In summary this report sets out the risk factors and circumstances of children under 1 year who suffer significant or fatal physical injuries and the improvements and changes required for us to be more confident that we have collectively worked together to minimise those risk factors and reduced harm to babies.

This report will be tabled at the Safeguarding Vulnerable People Partnership (Wiltshire's response to the requirement to set up new multi-agency safeguarding arrangements) to act upon both through its own work and that of its constituent parts – the Families and Children's Systems Assurance Group; the Wiltshire Adult Safeguarding Board and the Wiltshire Community Safety Partnership.

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