Kent Safeguarding Children
multi-agency partnership

Local Child Safeguarding Practice Review (LCSPR)

"Mira"

Overview Report V7 (FINAL)

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1. INTRODUCTION AND CIRCUMSTANCES LEADING TO THE REVIEW

1.1. This LSCPR was commissioned in line within the legal framework following a notification that, Mira, a baby of just under four months old of Eastern European origin, had received injuries consistent with having been caused non accidentally. A child safeguarding referral was made following Mira's attendance at the local emergency department. A consequent Rapid Review identified, that although there had been previous learning locally and nationally regarding injuries in under ones, there needed to be consideration in this case of any continuing blocks and barriers to professionals recognising the context within which babies are injured.

2. METHODOLOGY AND SCOPE

2.1. The terms of reference[1] identify the questions posed following the Rapid Review, key areas to be covered by the review and identified author for the review. The rationale for the review and scoping period is also covered in the terms of reference. The author considered the learning from previous reviews in the county as well as the recent publication of a National Practice Review[2].

3. FAMILY ENGAGEMENT

3.1. A key part of undertaking a LCSPR is to gather the views of the family regarding the services they received from agencies and share findings of the review with them prior to publication. Due to the ongoing police investigation, the Senior Investigating Officer advised the author not to have any contact with either parent at the time the review was commissioned. A letter (translated into their first language) was sent to parents to inform them that the review was being undertaken.

3.2. Once advice was received that the author was able to contact parents, further translated letters and contacts were made to enable arrangements to be made for a meeting between parents and the author. It is unfortunate that despite several contacts there was no communication with parents. This review is therefore completed without the information and aspect that family engagement can bring and is therefore a review from a professionals' perspective only.

4. BACKGROUND PRIOR TO SCOPING PERIOD

4.1. Mira was the first and only child of Mother and Father who were 34 years and 29 years of age respectively at the time of the incident. Both parents are of Eastern European Origin. Mother moved to the UK from her country of origin when she was approximately 26 years old. There were conflicting reports regarding the amount of time that Mira's parents had been together ranging from a few months to a few years. The consensus was that the relationship had started just a couple of months before the pregnancy was confirmed. Information received for the review suggested that Mother had been a victim of domestic abuse within previous relationships.

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[1] Redacted for publication.

[2] The Child Safeguarding Practice Review Panel (2021) 'The Myth of Invisible Men' Safeguarding Children Under 1 From Non-Accidental Injury Caused By Male carers. 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

4.2. Information submitted to the review suggested that Mother had a difficult childhood and had suffered some trauma in her younger life. The review heard from those that had worked with Mother, that this had an impact on her mental health and was one of the reasons for her move to the UK. Mother had worked in a recruitment role but was furloughed at the start of the Coronavirus pandemic, leaving her concerned about her financial and living situation.

4.3. It is not known how long Father had lived in the UK, but it was known that he had family living in a nearby city and that he was working but no other details are recorded about him.

5. KEY ISSUES IMPACTING ON MIRA DURING THE TIMEFRAME OF THE REVIEW

5.1. This section will very briefly identify the facts of the key issues that may have had an impact on Mira as a young baby. It is not the intention of this section to go into any details here as this will be undertaken in the thematic analysis section.

Parental Mental Health

5.2. The review heard how Mother had experienced mental health issues such as anxiety and depression for some years, had previously taken overdoses of medication and was subsequently diagnosed with Emotionally Unstable Personality Disorder (EUPD)[3] 18 months prior to the timeframe of the review. Mother had received services of the Mental Health Trust and her GP to manage these symptoms previously and presented herself as concerned when she found out that she was pregnant at the start of the review period. This resulted in a referral to specialist perinatal mental health services to support her to manage her symptoms through her pregnancy and beyond.

5.3. This evidenced that Mother had good insight into her mental health needs, and indeed she often mentioned symptoms to staff that showed good awareness that the impact of EUPD may have on her and those around her. Difficulty in managing her emotions and relationships were often put forward by others as the reason for the domestic abuse in the relationship with Father. Mother was very clear that she wanted support with therapy in order that her mental health issues would impact on Mira as little as possible.

5.4. It is of note that Mother was particularly excited to find that she was pregnant as she had always thought that she would be unable to become pregnant due to a benign brain tumour that creates hormone imbalances. This could therefore have had a positive impact on her mental health.

5.5. Whilst it is often argued that parental mental health can have an impact on an unborn and the born child, that is not always the case. Many parents manage their mental health with great insight

[3]**Emotionally unstable personality disorder** (**EUPD**) also known as **borderline personality disorder** (**BPD)** is a personality disorder characterised by a long-term pattern of unstable interpersonal relationships, distorted sense of self, and strong emotional reactions. Those affected often engage in self-harm and other dangerous behaviours, often due to their difficulty with returning their emotional level to a healthy or normal baseline. They may also struggle with a feeling of emptiness, fear of abandonment, and detachment from reality. Symptoms of BPD may be triggered by events considered normal to others. BPD typically begins by early adulthood and occurs across a variety of situations. Substance use disorders, depression, and eating disorders are commonly associated with BPD. Approximately 10% of people affected with the disorder die by suicide. https://en.wikipedia.org/wiki/Borderline_personality_disorder - cite_note-16 (Taken from Wikipedia- Information independently checked for accuracy).

ensuring that the impact of their own conditions have on their children is minimal or negligible. This will be discussed in section 6 later within this report.

5.6. Once Mira was born, some minor medical issues required attention. One of these impacted on Mira's ability to breast feed, whilst these were successfully manged and treated, they put additional stress on Mother at that time.

Father

5.7. Father had different mental health needs; these were largely unknown and only reported by Mother. The Police report for the review noted that Father was drunk on two occasions where they were called, and that it was his drinking that had caused arguments between the couple. It was also noted by Mother that Father regularly used cannabis and that along with alcohol was known to affect his presentation and had a negative impact on the relationship.

5.8. At the start of the review period Mother stated that she was not in a relationship with the father of her unborn baby for the above reasons.

5.9. From Mira's perspective this meant that both parents were impacted by mental health issues and struggled to manage their relationship. This was therefore likely to lead to raised voices, difficulty in coping with situations that others might ordinarily cope with, leading to instability for Mira's security and confidence development.

Domestic Abuse

5.10. The impact of domestic abuse on the unborn and all children within relationships where domestic abuse is a feature has been well written about.

5.11. Mira could have been hearing any arguments within the relationship from when their hearing developed in utero from about 18 weeks and was also at risk of any physical violence as an unborn. It is also known that cortisol, a stress related hormone, can cross over the placenta and in some cases has long term impact on the baby.[4]

5.12. The first reported incident of abuse to the police came when Mira was about six months gestation, this is a time when a baby becomes more sensitive to sound and would also be affected by increased infant cortisol according to recent research[5]. It is not known if the relationship had previously been one where arguments spilled over to be abusive; it is known that Mother had been a victim of domestic abuse in previous relationships and that she had told professionals that she was no longer with Father after she ended the relationship because he was unreliable and not a suitable father for her baby.

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[4] REGE, S. & Graham, J. (2017) The Impact of Maternal Stress on the Fetal Brain – A Summary of Key Mechanisms https://psychscenehub.com/psychinsights/maternal-stress-and-the-fetal-brain/

[5] Zietlow, A. L., Nonnenmacher, N., Reck, C., Ditzen, B., & Müller, M. (2019). Emotional Stress During Pregnancy - Associations With Maternal Anxiety Disorders, Infant Cortisol Reactivity, and Mother-Child Interaction at Pre-school Age. *Frontiers in psychology*, *10*, 2179. https://doi.org/10.3389/fpsyg.2019.02179 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6773887/

5.13. It is therefore very likely that Mira was being affected by the nature of the relationship. The practice experienced by the family from professionals will be reviewed in the next sections.

Born to minority ethnic family

5.14. Mira was born to Eastern European parents, who had come to the UK in their adult years and had met in the UK. It appears that Mother had settled well and had a good command of the English language. Information gathered for the review would suggest that Mother had some good friendships.

5.15. It is not clear when Father came to the UK, but it was suggested that Father had a much lesser understanding of English and that Mother and other family members translated for him on occasions.

5.16. The demographics from the 2011 UK wide census provide data that indicates that the Eastern European population is one of the largest ethnic minority groups in the town where the family lived.

5.17. The cultural competence of professionals to understand the impact of the minority ethnic status and Eastern European culture on Mira will be explored in all other sections as this could have had an impact across various elements of Mira's life.

Housing and financial circumstances

5.18. The review heard that Mother rented a house from an Eastern European landlord and had lived there for several years. The Covid Pandemic limitations on work affected Mother and she was furloughed; finances became more difficult and paying her rent became an issue. During the timeframe of the review, it was identified that the landlord had moved other men of Eastern European origin into the property so that with the further contributions to the rent, Mother's rent payments could be reduced. Being furloughed also had an impact on overall ability to pay her bills. Mother raised concerns with professionals that her accommodation was not suitable and that, due to the rules of the tenancy, she would not be able to stay at that property if she had children.

5.19. The impact on family finances and circumstances during the pandemic were managed at government level and there were instructions that people should not normally be evicted during this time and that any notice period would be extended. This was in place throughout the timeframe of this review.

5.20. How professionals understood the living circumstances of Mother and Mira and any risks that this may pose to Mira will be discussed within section 6 of this report.

6. THEMATIC ANALYSIS

6.1. The analysis section takes a strengths-based approach identifying what went well and then building from the Rapid Review and the LSCPR a picture of areas where learning has been identified, as well as further steps that should be taken to achieve stronger systems. Systems and services that worked

with this family may have been updated and improved since this case. This is due to natural ongoing improvement, service changes, and elements that may have been changed already due to early learning from this review. These, as well as where agencies have identified their own learning will be noted throughout this report.

Cultural Competence

6.2. Culture is defined as "the attitudes, habits, norms, beliefs, behaviours, customs, rituals, styles and artifacts that express a group's adaptation to its environment; that is, ways that are shared by group members and passed on over time" [6]

6.3. Following on from that, cultural competence is defined in various ways but again covers, in general, a range of cognitive, affective, and behavioural skills that lead to effective and appropriate communication with people of other cultures. Intercultural or cross-cultural education are terms used for the training to achieve cultural competence.

6.4. One of the main questions that arose from the Rapid Review was whether professionals were culturally competent in their work with this family. This is an important question to answer given the data discussed above regarding the demographics within the town.

6.5. Health and Social Care organisations place great emphasis on person centred care. In order to offer person centred care, professionals must be able to have an understanding of a person's cultural values and norms, including how they communicate. Professionals also need to be able to consider any influences from being part of an ethnic minority background.

6.6. During the workshop session with the professionals, the review found, from a language perspective, that Mother spoke good English, had worked for several years as a recruitment consultant and had no communication problems. Whilst this may have been true, there are nuances in spoken English that may create communication difficulties. In a further discussion with professionals, it was highlighted that in the area of the country where they live and work, the dialect can also be difficult to comprehend if English is not your first language with various types of colloquialisms. In a research article[7] regarding how management teams communicate where English is the first language of some and a second language for others, it is cited that second language speakers can transfer cognitive and communicative habits to their second language. Sometimes these are obvious and sometimes they go undetected and can create misunderstandings. There is a possible example of this, when Mother told the family partnership nurse that the Early Help was ending when in fact it was a change of worker.

6.7. Another issue for Mother was when she was trying to communicate with housing regarding the issues that she was worried about. It was clear that she was concerned that any rented property she was to move to would have to allow dogs, and whilst the housing officer she spoke to was clear that

[6] McAuliffe, G. (2013). Culturally alert counseling: A comprehensive introduction. Thousand Oaks, Calif: SAGE Publications

[7] Ketil, A. Wanwen, D. Hui, L. & Zhe, N. (2021) Limits of a Second Language: Native and Second Languages in Management Team Communication. Frontiers in Psychology. Vol:12 https://www.frontiersin.org/article/10.3389/fpsyg.2021.580946

Mother was less likely to find somewhere that would accept dogs, it did not appear that Mother was able to understand that there may be options. Although this has been suggested as a communication problem, the Family Partnership Lead, who knew Mother very well, was clear that assumptions could not be made that this was a language issue. Mother had a great bond with her dog, and that Mother may not have listened after she heard 'difficulty with the dog'. This highlights well that we cannot always assume that language is the cause of a communication difficulty.

6.8. There were other issues that were housing priority that would have meant that Mother would be eligible for rehousing via the local authority that were not communicated to the housing team when Mother spoke with them. It is not clear if this was because her communication skills were not at a level to manage complex conversations. The open access worker and the family partnership lead encouraged mother to make her own contact. Whilst Mother had the skills to speak in English to the housing worker and was being encouraged to be proactive, the open access worker did contact housing to ensure that the housing form had been completed as it did not appear if Mother was sure that it had been done. It may have worked better for the worker to have identified what was recorded on the form whilst the call was taking place on finding out that the application had been rejected. This would have raised an issue about the discrepancies between the professionals' concerns regarding housing over what Mother had told housing and would have ensured any communication issues were not going to impact the addressing of her housing needs.

6.9. These nuances in communication need to be understood and whether the spoken English is reported to be good, there can be communication difficulties that remain. Mental Health Services offered the support of an interpreter at one of the assessment appointments prior to the review timeframe but Mother stated that her English was good enough and that she did not require one. An interpreter was not offered during the timeframe of the review. It is important to note that understanding of conversations were continually checked by the family partnership lead and the open access worker spoke the same language. For future working and learning, the recording of offers of interpreters, refusal and communication that there is a risk of not using interpreters, and ways of ensuring robust language understanding should be evident in records as per the NHS Community Trust's policy.

6.10. When it came to Father, his spoken English was not as good. There was evidence that other members of his family and Mother translated for him. Whatever the level of spoken English, it is best practice for the practitioner to gain a sense of the communication challenges by asking the individual to relay to the practitioner what they have understood from the conversation, identifying interpreting services, accordingly, not relying on family members as conflicts of interest would likely influence communication. Most NHS and other organisational interpreting and language policies highlight that family members, friends and professionals that are not trained interpreters must not be used as interpreters.

6.11. On one occasion, Father was held in custody following a domestic abuse incident, the Mental Health NHS Trust Criminal Justice Liaison and Diversion Service were requested to undertake a screening assessment; an interpreter was not used. This was analysed in the agency report for that organisation with learning identified. Staff in that situation explained that the pace of the environment and the speed at which the assessment needs to be offered can often mean that there

is not an opportunity to access interpreting services. This was discussed at the learning workshop; there is learning that has already been identified by the Mental Health Trust but is relevant for all services. It was stated that Father refused a full assessment by the Mental Health Team; without an interpreter it is doubtful that he would have understood the full purpose of the assessment and the assessment would certainly not have been able to be undertaken with the limited understanding and communication that he had.

6.12. There were professionals at the workshop who felt that Father understood more English than he indicated. Even if that were so, there are reasons why an interpreter should be used in these circumstances, one is because of the communication issues outside of spoken English mentioned above that need to be accounted for. Although language is not of the protected characteristics within the Equality Act; a person who is entitled to treatment and/or assessment must not be a disadvantaged because they speak a different language. This, for at least NHS staff is in line with the National Health Service Act 2006 which states,

> 'NHS England, in the exercise of its functions, must have regard to the need to reduce inequalities between patients with respect to:
>
> - Their ability to access health services; and
> - The outcomes achieved for them by the provision of health services.[8]

6.13. Culture is more than language though and it is important to understand what a person's culture means to them. This can only be achieved by asking the person about their culture. This would appear to be the only way about understanding the person's lived experience of being from another culture and living in the UK.

6.14. There are many beliefs that come from cultural roots, some of more traditionalist aspects of culture may not continue to be supported by the younger generation of a culture; cultures change and move on. All of this is important when working with a person from a different culture than their own, especially where that particular ethnic group may represent a large proportion of the local population. Professionals should have a conscious understanding of how their culture differs to others and how cultures may understand specific experiences with a different understanding of context. In the Care Quality Commission's advice to health and social care providers[9], it is pointed out that culture not only covers how people speak, what their food preferences are but other elements of general life situations that others may misunderstand. For example, some cultures value being more than doing, others may be more competitive than collaborative.

6.15. It is noted that Mother was allocated an Eastern European open access worker, which was discussed within the review information and learning events as ideal practice as it would have helped communication and understanding of culture as discussed above. It is of note that there is no record of Mother being asked if this would be her preference. Sometimes it may be that people can express concerns about having a worker from their own community particularly in a small close-knit community where there are close relationships within the community. In fact, this did become an

[8] https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2019/04/guidance-v61-published-310818.pdf
[9] https://www.cqc.org.uk/guidance-providers/adult-social-care/culturally-appropriate-care

issue in that there was a noted conflict of interest within friendship groups as the open access worker and mother had a close friend in common. The Domestic Abuse support officer gave Mother the details of a support group for those who are victims of domestic abuse in the Eastern European community, another recognition of the need for specific support for those from different cultural backgrounds.

6.16. Children's social care have recognised the need for training regarding cultural competence and implemented a programme of quarterly sessions aimed at developing awareness of equality and diversity. Other agencies will have Equality and Diversity Polices and Strategies as well as other methods of recognising diversity. Cultural competence goes slightly deeper than recognising diversity, it ensures that a person understands their own culture and is accepting of other cultures as well as ensuring that the workforce actively seeks to understand the influence and any impact of the person's culture from their own perspective. Partner agencies will need to address their understanding of cultural competence.

6.17. It is noted on researching cultural norms for the Eastern European community[10], that the country experienced communist politics and values at the time that Mother was born. Reading regarding other aspects of culture suggests a culture where the father as head of the family was the steer or 'Captain' and therefore a very important role. Whilst it could be said this is true of many cultures, recognising this as a possible explanation for why, despite the relationship difficulties Mother and Father experienced, that Mother, following birth saw it was very important Mira should have their father in their life. This could only have been known by asking her.

Points for strengthening practice

- Cultural competence allows for person centred assessment and care delivery
- English as a second language may cause communication difficulties in the way that language is communicated and expressed.
- To be culturally competent is to seek out from the person what their culture means to them as well as some basic information regarding the cultural roots of a person. This will lead to a respect for differences and enhance relationships
- Best practice would indicate that staff have an understanding of the cultures of the population that they work most frequently with.

6.18. It is clear, therefore that to be culturally competent not only means understanding some of the communication difficulties even where someone appears to be able to speak and understand English, but that there are no assumptions made about the culture of a person. Asking a person about what their culture means to them is a good way of achieving this; there is no recorded evidence that anyone asked Mother (or Father) about their culture, what it means to them and the positive or negative impacts of this.

[10] Oleksandr, R. Johannessen, O. (2015) Review of research literature on Parenting styles and childrearing practices among Poles: Historical and Contemporary Perspectives. Report prepared in the framework of The Eastern European-Norwegian Research Project PAR Migration Navigator.
: Misjonshøgskolens forlag https://vid.brage.unit.no/vid-xmlui/bitstream/handle/11250/2354170/2015.3.SIK-report.pdf?sequence=1&isAllowed=y

Father

6.19. As stated before, there is a consensus that Father had been in a relationship with Mother a couple of months when the pregnancy was confirmed.

6.20. It was reported that Father too arrived in England to live as an adult and that his mother and siblings also lived in a nearby city. Very little was known about him during the timeframe of the review and what was known was relayed by Mother to professionals working with her. When Mother was first pregnant and being seen by the midwife, it is recorded that Mother stated that she was not in a relationship with the baby's father. The family partnership lead (health visitor intensive support role)[11] recorded that Mother felt that the baby's father would not be reliable. That was the position known to most of the professionals involved in the antenatal period; that Mother was a single parent. It is noted that (and covered in more detail the next section) that the Police did believe that Father and Mother were in a relationship as they were called to domestic incidents. On the first of these occasions, they had no interaction with Father as he had left the house by the time police arrived, but Mother described him as her partner and that she was angry with him because of his use of drink and drugs. Later during the timeframe of the review, Mother talked about Father's mental health issues.

6.21. It was only when Mother went into labour that Father appeared to be part of the family. Hospital staff did not record who the man with Mother was. It appears that assumptions were made that he was the father of the baby; nothing is recorded about him in the hospital records. The Hospital NHS Trust have noted this as learning for their organisation and made recommendations that birth partners' details should always be recorded. The Open Access worker tried to engage with Father but was not able to as he did not return calls.

6.22. Once Mother and baby were discharged home, Father was present at midwifery and family partnership visits. No further details were discovered about Father in this time. It was accepted that Mother felt that he was being a great help and that her baby needed a father. Father was given the option to become involved in the visits but declined. At this stage, all of the services offered were on a voluntary basis and therefore there is no compulsion on fathers, or even mothers, to be involved in health or early help services.

6.23. Even as the domestic abuse incidents were happening more often and risk was increasing, there was still no more known about Father, other than his behaviour that was identified as domestic abuse. At the point of the Child and Family Assessment, Father would not engage with the social worker.

6.24. The review found that no one had any information about Father other than he lived in another city The CCG report for Father's GP indicated that he attended an orthopaedic appointment in the City where he lived, for a shoulder complaint. It was then discerned, following a review of the

[11] **Family Partnership Programme** is part of the Health Visiting service and is designed to meet the needs of families who need extra support. The programme is open to women from 28 weeks of pregnancy, and their families, up to a child's first birthday. The FPP aims to empower parents and help them and their family to lead a happier, healthier life. It is available to families living in the County who have experienced difficulties such as poverty, mental health issues, family problems or domestic abuse.

information, that this had been a telephone call (Covid restrictions), that Father was not available, and the consultation took place with his sister. Father's sister disclosed domestic abuse between Father and his 'wife'. The shoulder issue was said to leave him in chronic pain, leaving the doctor believing that surgery may be necessary. Chronic pain does not appear to have been known by anyone else, so it is not understood whether this had an impact on his mood or his drug and alcohol intake. It was believed by professionals that Father did work but no more details about this are known.

6.25. When the social worker requested Police checks for Father, these were only undertaken in relation to the Police force local to Mother; checks with the local police force to where Father lived were not undertaken. This has been recognised by Police as learning for their agency.

6.26. It is not an unusual situation when undertaking LSCPRs, and previously Serious Case Reviews, for the Father of the subject child/ren to appear to be invisible or that very little is known about him. Reviews both nationally and locally have identified the risk that fathers may pose when it is unknown and unassessed or indeed the opposite, that the possible protective factors that fathers may offer are not known or assessed.

6.27. A learning briefing by the NSPCC in 2015[12] identified similar issues and was referenced in a previous Serious Case Review locally that has only recently been published. That review identified the importance of including Fathers, absent or living in the household in assessments so that they are understood. The recommendations from that review have now been implemented and will need further exploration and escalation to ensure that the learning is embedded.

6.28. The most recent review by the National Safeguarding Practice Review Panel[13] identified that perpetrators of physical abuse causing injuries in under ones are predominantly the birth fathers. The panel have identified that evidence suggests that some men are very dangerous, but that service design and practice tends to render fathers invisible and generally 'out of sight'. In this case Father was present at visits but declined to be involved in any assessment or engage with any service. His impact was not understood enough to safeguard Mira.

6.29. The National Panel Review argues that ultimately the way that safeguarding services are organised makes it too easy for fathers who wish to, to remain anonymous and unengaged. It is startling to realise that the biggest number of serious incident notifications involved serious harm to under ones, that these are mostly due to physical injuries and more likely to be perpetrated by males who are often 'hidden'.

6.30. The reason that assessment of fathers is so vital has been explained to some degree by the report finding that the contextual elements that link to the increase of the risk of the abuse of infants. It is identified that these fathers have often suffered from poor parenting themselves, especially

[12] **Hidden men: learning from case reviews** NSPCC 2015 https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/learning/hidden-men/

[13] Child Safeguarding Practice Review Panel (2021) **The Myth of Invisible Men** Safeguarding children under 1 from non-accidental injury caused by male carers September 2021 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

including abuse and neglect then as an adult using substances where there is a co-existence of domestic abuse, other social difficulties and problematic relationships with the mothers of their children.

6.31. In this case, there were no additional safeguards in place as part of the Child in Need Plan to keep Father away from the family because of his unknown/unassessed risk. Professionals were confident that with bail conditions to stay away from Mother and Mira that he was not having any contact. It will therefore be imperative that understanding the risk of unassessed fathers is addressed by this review to safeguard under ones.

6.32. The review has tried to understand why Father was not challenged more or 'expected' to be involved as a Father. Whilst professionals at the learning events were unable to identify any barriers, the panel gave further thought and used their overarching knowledge of services and systems to identify several factors.

6.33. It was noted that the requirement of the family partnership service does expect the inclusion of fathers by its very name but that, in reality, many of the assessments appear to be geared to maternal and baby health. Assurance has been given to the review that this is not the case and that assessments are geared to assessment of the whole family, however that family is made up. There was a concern expressed by panel members that the room for professional judgement on when to visit may have been removed with a more set schedule of visits within the health visiting service. This family had the service of a family partnership lead which enables many more visits to be undertaken as well as professional judgement if more frequent visits should be undertaken or indeed in response to specific issues that arise. It is noted by the author that the list of subjects for discussion in the antenatal period does not include any mention of father/partner. There is a mention of relationships lower down the list, but it is not highlighted as crucial/important information. This review recognises that not all relationships would be of a heterosexual nature and there may be other parental relationship types; within this review the father was a male within a heterosexual relationship and more information could have been gleaned about him from many of the assessments that were undertaken.

6.34. Albeit that the above is about the family partnership service, it is of note that no professionals engaged successfully with father during the review period. The 'voluntary' nature of engagement at the level of need that Mira was assessed at, appeared to mean professionals viewed that they had no ability to be more insistent on engagement which gave Father an 'opt out' and engagement was not pursued. The panel discussed 'bravery'. Professionals did not indicate any fear or intimidation from Father, but the panel thought the skill level of the professionals may have had a part to play. Social care services identified that many of their practitioners are newly qualified or have qualified in more recent years and that there may be a dearth of staff with a greater level of experience and expertise. The hypothesis being the ability to have those brave conversations possibly comes with that experience. Family partnership leads need to have been qualified for 5 years before they are able to apply for the role and therefore would therefore have experience.

6.35. The system needs to support less experienced workforce to challenge and engage more assertively to engage fathers. Children's social care have reconsidered the roles of more junior managers to

ensure senior managers with more experience have line of sight to support less experienced staff, managers are provided with training opportunities whilst providing regular training opportunities led by subject experts to develop staff confidence. Other agencies will need to consider strategies for supporting and mentoring a less experienced workforce.

Points for strengthening practice

- Fathers can play an important role in the lives of their children; including them in assessments is as important as including mothers.
- Good understanding of the role that a father plays within a family can help the understanding as to whether father plays a positive supporting role and is a positive role model for growing and developing children or whether they are likely to be considered as posing a risk
- It is important that learning from previous reviews is embedded. The model for monitoring actions from reviews offers insight into outstanding learning to be addressed.
- Supporting brave conversations may have an influence with engaging fathers

Domestic Abuse: Escalation and cumulative risk for Mira

6.36. The Rapid Review identified that it was the contextual and cumulative risk that was a key feature of this case that needed further exploration.

Referral assessment and support pre 1st DA incident

6.37. There were several areas where referral assessment and support indicated strong practice. The GP referred to talking therapies, a primary care mental health service commissioned by the CCG, on recognising that mental health issues may be exacerbated in pregnancy. Likewise, the talking therapies team recognised that as a pregnant client, Mother's mental health needs may require specialised care and therefore a referral was made to the perinatal mental health service provided by the Mental Health NHS Trust.

6.38. The first midwifery appointment was a telephone booking appointment and the second one was in clinic. These were the arrangements due to service changes because of the Covid pandemic. As the midwife recognised that there were some concerns, a decision was made to undertake a home visit. This was really positive practice and highlights changes in practice due to Covid did not always mean no face-to-face contact with professionals. The midwife also recognised several areas where it was felt that Mother required extra support. These were as follows:

- Concerns regarding finances due to being furloughed and pregnant
- Housing not suitable as landlord did not allow children and Mother lived with other unrelated males in an ostensibly multi occupancy house
- Isolation

6.39. As a result, the midwife sent a referral to the 'Front Door' of Children's Services. It was identified that the threshold for need was at level one and that Mother could be signposted to those that could offer support e.g., housing and was already getting support for her mental health. The

thresholds for services at different levels of need are identified in the Kent Support Levels Guidance[14]

6.40. A further referral was made by the midwife directly to the Open Access Team service at level two (according to the Support Levels guidance) as it was felt that the needs did not meet the criteria at this stage for intensive family support or specialist support (level three and four). This referral happened via an old form and has identified system recording errors that will need to be clarified as part of the learning from this review.

6.41. Professionals referring into services reported being confused at the different ways of making referrals and at the 'Early Help' terminology that is commonly used at levels two and three. The terminology 'Open Access' is not used in the Support Levels Guidance and Early Help terminology is used at Level three. The use of 'Early Help' terminology on the Kelsi website discusses Early Help at level two. This review will seek to resolve these issues as it would work better if everyone used the same terminology and understood the levels and the required referral pathways.

6.42. The direct referral was accepted by Open Access and a worker who was from the same ethnic origin, was allocated. (This was analysed in a previous section.) At this stage there had still been no domestic abuse incidents identified to the Police. There was therefore some excellent work being undertaken by individual agencies albeit that there was little communication between them at this point.

6.43. During the open access work, it was identified that Mother was looking forward to the birth of her baby and was excited to be pregnant as she had believed that she could not be pregnant because of her tumour. Mother told professionals that she wanted to offer her baby a better experience as a growing child than she had experienced (paraphrased by author). It was also identified that Mother was accepting of help and support and was seen as very open and honest about her difficulties.

Referral, assessment, and support post 1st DA incident

6.44. The previous sections have analysed and found learning related to the contextual information i.e., that Mother had mental health needs, was a lone parent socially unsupported, that very little was known about Father and that this was a mother who needed some support to enable her to parent effectively in the way that she wanted.

6.45. It was only when Mother was seven months pregnant that elements of risk increased when Police were called to a domestic incident at her home. This was the first interaction with the Police. The incident was graded at standard risk and there was no information sharing for this or the next four incidents that Police were called to. Most of the incidents were related to ones where Mother and Father were arguing due to Father's drinking and drug taking and irresponsible behaviour such as attempting to drive whilst drunk, according to Mother.

[14] https://www.kscmp.org.uk/guidance/kent-support-levels-guidance

6.46. The first three incidents occurred antenatally and the fourth was when Mira was four weeks old. During this period there were several other professionals working with and seeing Mother. There were some occasions where Mother mentioned pieces of information to professionals but none of these were exactly the same pieces of information. Between the second and third incidents, in a letter to the GP, the Talking Therapies worker shared that a safety plan had been discussed and that there was stress and anxiety regarding her partner's drinking. It was confirmed that the safety plan was a mental health safety plan.

6.47. At this point, all other professionals still thought that Mother was a single parent, although she had indicated to the midwife that her partner was not causing problems but that she did not want the relationship to continue. The first four incidents of domestic abuse were only known to the police and had been low level incidents, the cumulative impact, however, and the regularity that Police were now being called (four incidents in four months) was not understood.

6.48. In producing their learning for this review, the Police have rightly identified some system issues that have not supported the correct sharing of these lower-level incidents and have made appropriate recommendations to address these. Each incident by itself was not graded higher than medium, but the cumulation and regularity should have prompted referral to social care. Police officers were aware that mother was getting support from mental health services and a midwife but not about the Open Access Team involvement.

6.49. When the Family partnership lead carried out the antenatal contact, Mother disclosed that she was not in a relationship with the baby's father due to physical abuse. Mother shared that she was being supported by Early Help (Open Access- level two).

6.50. Whilst there was some communication between the midwife and the open access worker, most of the authors for the agency reports identified that there was little communication between those working with Mother.

6.51. It became clear that, albeit that there were some disclosures regarding police being called and about her partner not being a reliable person, Mother presented as a very engaged mother-to-be. Despite Mother's mental health leaving her feeling low at times, she engaged positively with workers and showed excitement and a keen interest in aspects of managing a baby such as feeding and sleeping routines. It was not possible for individual professionals to see that Mother was playing down and blaming herself for the issues that her partner was presenting and changing her story to the Police regarding coercive and controlling behaviour. At this point, it was still believed by most professionals that Mother was single.

6.52. The review has considered that most professionals did not understand the impact of Mother's EUPD diagnosis may have had on her ability to be consistent and reliable in what she was telling professionals. There may have been aspects of EUPD that were being played out in the relationships Mother had with professionals as well as any unrecognised or denied coercive control. These elements made it more difficult for professionals to determine risk. Professionals were not able to display a respectful uncertainty nor curiosity to understand the family situation further and to liaise together to identify an overall picture that included all perspectives. This could again be due to the

reasons stated in the previous section regarding an inexperienced workforce.

6.53. Previous studies regarding learning from SCRs, the Triennial Analysis of Serious Case Reviews[15] and Lord Laming in his review into the death of Victoria Climbié[16,] indicated that it is important to maintain a respectful uncertainty of parents/carers. It is suggested that it is possible to do this without affecting the professional/patient/client relationship.

6.54. To ensure that assessment is comprehensive, robust and child centred, professional curiosity is needed whilst maintaining a healthy scepticism of the issues that are being presented. Sidebotham (2013)[17] identified that this is only possible if professionals are able to adopt authoritative practice. This authority comes from competence and confidence whilst practising. It requires empathy to keep the child at the centre whilst considering the needs of the parents. This then necessitates humility from professionals who are willing to accept the limitations that they may have in their knowledge and skills to seek advice, supervision and guidance. This review has identified issues with not having an authoritative workforce as identified above.

6.55. The author would suggest that many of the issues that the case has highlighted may have been more thoroughly addressed if practitioners were able to communicate with each other more effectively. As the requirement for professional curiosity by using authoritative practice has been known about for some time, it is important to question what the barriers were to effective information sharing in the early part of this case. The author would suggest that there may have been an element of disguised compliance by Mother as a result of her EUPD and coercive control. It came to light that one of the things that Father was telling Mother was that he would make sure that social services took her baby from her as she was not a good mother. There was also evidence of Mother playing down the domestic abuse which would not be unusual if she feared her baby being removed. After Mira was born, the attention that she showed and the interest in ensuring that she was providing the best care for Mira appeared to be a barrier to professionals recognising that even the best most caring and nurturing mother may not be able to keep a baby safe from someone who was abusive and controlling. Whilst Mother may not have recognised this, the professionals could have.

6.56. At this point there were eight agencies involved (or had been recently) with Mother[18]. Following the dissolution of Common Assessment Framework, where it was usual for professionals and families to meet together at level two without the need for a social worker, this does not appear to be usual practice now. The Support Levels Guidance does not suggest or encourage meetings to share all information at this level and may be another reason why silo working continued at this point. This review will address this as a matter of urgency.

6.57. It is also true that the country was in the midst of the Covid Pandemic during this case. Organisations had changed the way that they delivered services and professionals were very busy as well as covering caseloads of those that were absent from work or had been redeployed to manage the pandemic response. It was also the case that face-to-face meetings were no longer taking place. The

[15] Peter Sidebotham et al. (2016) Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014 London, Department for Education

[16] The Lord Laming, (2003), The Victoria Climbié Enquiry

[17] Sidebotham, P. (2013) Authoritative Child Protection. *Child Abuse Review*, 22(1): 1-4

[18] Agencies involved: Midwifery, Perinatal Mental Health, Police, Family Partnership, Housing, GP, Open Access, Talking Therapies

ability for all agencies to use and be confident in virtual meeting technology did not happen until later. The technology was available, but many professionals were not confident in its use; it has now, however, become second nature.

6.58. In order to support professionals in children's social care, managers increased the number of meetings with staff to increase contact whilst remote working and being in isolation. Other agencies reported that supervision was affected by the pandemic and did not always get prioritised. Although this was the case, safeguarding leads in organisations were available to seek advice from, the barrier here appears to be that professionals did not think that this family were causing sufficient concern to seek advice, support and guidance as they did not have the whole picture.

Referral, assessment, and support post 5th DA incident

6.59. When Mira was four weeks old there was a further incident. On this occasion it was reported by Father's sister that it was Mother that had been the aggressor. When Police visited the property, Father was not there. Mother explained that her response to him had been because he was under the influence of cannabis, and she had tried to leave the house with the baby. It was at that point that Father had assaulted Mother and threatened that he would call social services and have the baby taken away.

6.60. When Mother disclosed to the open access worker that she was exhausted, distressed and that Father was violent to her, despite finishing work at 4pm, the worker contacted the out of hours social work team as she was concerned about Mother and Mira. When Police were contacted by social care it was noted that the nature of the attack by Father the previous day, had reached the threshold for a social care referral. These two referrals coincided and because there was a physical assault and that Mother had been holding the baby at the time, there was an immediate strategy discussion between the Police and out of hours social care.

6.61. Although strategy meetings should always involve a health representative, this is not possible out of hours. It was noted within the reports and at the workshop that it was strong practice to have undertaken this strategy meeting out of hours. Given how little information is available out of hours it would have worked well to have had further follow up strategy meeting on the next working day and to have gathered information from all those who were working with Mother. This is expected practice and children's social care have recognised the need for further work to ensure that this happens. A time could have then been identified to have a full strategy meeting when it was realised how many DA incidents there had been and how many professionals were already working with Mother. This would have ensured comprehensive information sharing and planning.

6.62. Mother was indicating more information to different professionals regarding the abuse within the relationship and the times that the police were called; this did not invoke conversations with the now allocated social worker and the social worker did not contact all of the professionals. Five days later, the family partnership lead emailed the mental health worker regarding the concerns about the relationship between Mother and Father following Mother's disclosure about the recent police involvement; Mother made further disclosures at the next visit too. The strategy discussion was not known about at that point by either of these professionals although Mother did tell the family

partnership lead that she was expecting a visit from a social worker.

6.63. Following this, the open access worker referred Mother to a domestic abuse support service. This shows good recognition of the need albeit that it added another service for a Mother who was concerned about the number of services she was seeing. The support officer went for a walk with mother and the open access worker (due to Covid restrictions) this was evidence of some good co working. The support officer had also referred Mother to a support group for victims of domestic abuse for those of her ethnic origin, a further example of strong practice.

6.64. 13 days after the out of hours strategy discussion, an outcome strategy meeting took place that concluded the child protection investigation. The outcome was that a Child and Family assessment would be undertaken. The Family partnership lead, social worker and the police were in attendance. Missing from this meeting were the perinatal mental health team, the midwife and the GP. There is no recording that the GP, midwife or perinatal mental health team were contacted at any point for information to support risk assessment.

6.65. When it was discussed within the workshops that GPs generally do not attend or give reports for multi-agency meetings at any level, it was recognised, in this case, the GP had significant information filed in letters from the talking therapies service. The mental health team and the GP had information regarding Mother's long standing mental health issues and her previous crises. There will need be work undertaken to ensure that in the future there is full attendance and/or information from all services involved, including the GP. It is not possible to assess families and risk if there is vital information missing.

6.66. Although not known at the time, this point would become a pivotal time for the safety of Mira. It is important to not to use hindsight bias[19] here but to understand the situation from Mira's perspective as it became known and how it was that the risk to Mira was not understood.

6.67. 17 days after the strategy outcome meeting there was another significant incident of domestic abuse. This evidenced that Father was not staying away from the family. This incident included threats to kill from Father to Mother. During this period of time there are indications that Mother was blaming herself for some of the abuse in stating that she was struggling with her own emotional and anger management and had slapped Father. It is not unusual for victims of domestic abuse to blame themselves particularly where a controlling perpetrator may indicate to the victim that it is their fault that the perpetrator behaves and reacts in abusive ways. This information was shared by the police with social care but not until nine days later even though Mother disclosed to police that she had a social worker.

6.68. There was email correspondence between the perinatal mental health team and the social worker copied to the family partnership lead detailing information that they were aware of and concerned

[19] Roese, N. J., & Vohs, K. D. (2012). "Hindsight bias". *Perspectives on Psychological Science*, 7, 411–426. Hindsight bias occurs when people feel that they "knew it all along," that is, when they believe that an event is more predictable after it becomes known than it was before it became known. Hindsight bias embodies any combination of three aspects: memory distortion, beliefs about events' objective likelihoods, or subjective beliefs about one's own prediction abilities.

about. This is recorded the day before the next incident. The social worker had replied that they were working with the family and that an assessment was underway with a visit planned for the following week.

6.69. A further incident took place six days after the previous one and three days before the social worker was aware of that previous one. On this occasion mother had telephoned the Police to say that Father had been at the home under the influence of alcohol and cannabis and had refused to leave. Mother told the Police that there was a physical and sexual assault. When officers arrived Mother would not talk about the alleged sexual assault; specially trained officers were also dispatched to talk to Mother, but she did not say anything further. This information was not received by the social worker until eight days later.

6.70. All of this was happening against a backdrop of the Child and Family Assessment being undertaken. When the social worker visited Mother as part of the assessment, the analysis suggested a lack of confidence that Mother would be able to keep Father out of her life. The final outcome of that assessment was that the Mira's needs could be met at Child in Need Level. Ongoing risk of harm to Mira was not part of the written outcome. The assessment was completed without any engagement from Father as he did not return any of the social worker's calls. It does not appear that there was any comprehensive information gathered from other agencies to inform this assessment.

6.71. Father visited the home on two further occasions the following month. On the first occasion Mother reported that there were no issues but that she knew he was not supposed to be there, so she was reporting it to the Police. Four days later Father returned, and the behaviour described by Mother was that of stalking behaviour; Father was arrested on this occasion and removed to custody; he was bailed to stay away from the area that Mother lived in.

6.72. The Child in Need meeting took place eight days later. Mother and Mira were present along with the Open Access worker, social worker and family partnership lead. There were again key agencies missing from this meeting and no information from the GP who was not aware of any of the current issues. There are no minutes of this meeting and no recording on Children's social work records as to the outcome for this meeting and what the Child in Need plan would look like.

6.73. The other professionals who were present saw that mother was engaging with professionals, articulating that she would be keeping Father away. At this stage it appears that all of the responsibility to keep Mira safe was put on Mother and that Mother would continue to work openly and honestly with professionals. This again highlights how an apparently engaging parent can lead to an underestimation of the real risk posed by domestic abuse and controlling behaviours to very vulnerable babies and children. Five days later Mira attended the emergency department with injuries consistent with being non accidental in nature.

6.74. The whole of this final section has indicated a clear cumulation of risk that was not recognised by any of the professionals involved. There were several opportunities that were missed to use statutory processes. The first was when there were further domestic abuse incidents that included threats to kill, this could have resulted in a further strategy meeting to reassess information known to all agencies at that time. That particular incident and the following ones could have resulted in a

referral to Multi Agency Risk Assessment Conference (MARAC)[20].

6.75. There was no challenge by any agency regarding the level of need that Mira had been assessed at or that there had been no multi agency child in need meeting until five weeks later. There was no challenge or escalation when it was clear that key professionals were missing from important meetings or that risk to Mira was not part of the outcome to the Child and Family Assessment.

6.76. Escalation and challenge are an important part of multi-agency working and protects children when it is carried out professionally. The safeguarding partnership has escalation protocols that were not used. It appears that there was a culture of acceptance as to the way things are and not to challenge other professionals about their roles and responsibilities as each was seen as the expert in their field and 'they know their job'. This again can be recognised, as in the other sections, regarding a workforce who did not feel able to challenge and then escalate their concerns that there was no real assessment of all of the information known to all of the professionals involved. This learning does not appear to be about knowledge of the Escalation Policy but understanding that professional challenge and ongoing escalation, where necessary, is part of positive and effective multi agency working.

6.77. The work by all agencies was excellent in the support for Mother and the difficulties that she was experiencing from trauma in her childhood and as an expectant Mother and then as a Mother. Professionals were sometimes taken over by the needs of Mother in the way that her EUPD presented which was to be self-blaming about the impact her EUPD may have on her relationship, but also needing constant support and reassurance, managing her emotional highs and lows and dealing with her fear of abandonment. The work with Father has been analysed previously.

6.78. Professionals saw that Mira was growing and developing as expected and that Mother tended to all their needs and that she was emotionally responsive to them. This appeared to deter professionals from using their skills, knowledge and evidence base related to escalating domestic abuse, parental substance misuse and parental mental health and the particular vulnerability of under ones as being key risk factors for safeguarding babies.

6.79. It would have worked better if, on recognition by any professionals of the number of services involved, that a professionals meeting that included Mother had been held much earlier so that all information known by all was shared. Mother felt very much blamed and that the responsibility to keep Mira safe was all on her. More contemporary work with perpetrators and research into what

[20] **MARAC** A Multi Agency Risk Assessment Conference (MARAC) is a victim focused information sharing and risk management meeting attended by all key agencies, where high risk cases are discussed. The role of the MARAC is to facilitate, monitor and evaluate effective information sharing to enable appropriate actions to be taken to increase public safety. In a single meeting, MARAC combines up to date risk information with a timely assessment of a victim's needs and links those directly to the provision of appropriate services for all those involved in a domestic abuse case: victim, children and perpetrator.

works best is that perpetrators of abuse are held accountable and responsible for their actions rather than the victims and vulnerable.

Points for strengthening practice

- Referral pathways and terminology regarding levels of support that are clear ensure the right support is received in a timely manner
- Recognition of needs early in pregnancy can provide positive support for mothers to be in order that babies have most chance for positive outcomes.
- **Listening to parents is important; talking to other professionals is vital.**
- Sharing knowable Information in a multi-agency forum affords greater protection to vulnerable babies and children.
- Evidence base supports seeing past the presenting picture in recognition of risk.
- **Authoritative practice that includes courageous conversations can support maintaining a respectful uncertainty; respectful challenge of colleagues ensures effective safeguarding**.
- Professional challenge conducted with the child's needs at the centre, that leads to escalation if concerns are not allayed leads to effective management of risk.
- Pressuring victims of domestic abuse to be the sole protector of their baby underestimates the power of coercive control.
- Perpetrators of domestic abuse should be held accountable for their behaviours and safeguarding plans should include actions to keep all victims safe.

7. SUMMARY AND CONCLUSION

7.1. What happened to Mira was distressing for all who worked with them and their family. The Rapid Review identified that there was a lot of knowable information and set the LSCPR the task of understanding what could be learnt from how the risk escalated to the point to which Mira was found to have non accidental injuries.

7.2. In summarising and concluding what the review has found, it is useful to consider the Triennial Analysis of challenge and complexity[21]. The continued use of the pathways to harm, pathways to protection model is a useful framework to use for this.

7.3. The contextual information related to the characteristics of the family have been explored; the family are from a minority ethnic population but one that that forms a large part of the local community. Mother was struggling with her own mental health from childhood trauma and felt initially unsupported. The impact of the pandemic on her had left her concerned about finances and her pregnancy had left her concerned that she would be homeless. The further characteristics were signified by very little being known about Mira's father, but that Mother had stated she would not have him in her life as he had mental health and substance misuse issues.

[21] Brandon, M et al (2020) Complexity and challenge: a triennial analysis of SCRs 2014-2017 Final report Department for Education March 2020, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/869586/TRIENNIAL_SCR_REPORT_2014_to_2017.pdf

7.4. The learning for cultural competency is that professionals should seek to understand if there are elements of culture impacting on the safety of a child whilst respecting differences. There was little curiosity as to why Mother appeared to have a complete turnaround in her view of Father and that he was at the birth and post-natal visits. Was this because of controlling behaviours or because culturally a father is seen as an important part of the family? Was it because of the circumstances that Mother had been brought up in and that she wanted better outcomes for her child than she had experienced? Mother was not asked about these issues, and it appears that this was due to a lack of confidence to address queries or apparent view there was no need to ask.

7.5. The learning for knowledge of fathers surrounds the critical understanding of the role that they play in the family. Any risk posed by a father who opts out of engaging with services needs to be considered against everything else that is known about a family. Decisions can then be made as to whether a child remains safe.

7.6. The pathways to harm that emerged were the domestic abuse that was first known about by police when Mother was seven months pregnant. Father then appeared to be very much part of the family at labour and delivery and following birth; he would not engage with professionals and there was still virtually nothing known about him throughout the period covered by the review. Harm was escalating as the domestic abuse continued, but little was known of this by agencies other than the police until Mira was four weeks old.

7.7. The pathways to prevention and protection were the services that were being offered to support Mother in her parenting role by a consistent team of professionals. This was all positive and helped to build a relationship between Mother and the professionals. The referrals made, and work undertaken by various professionals were also protective. That said, however, there was no multiagency meeting involving all the professionals that were working with Mother and then Mother and Mira at level two support level. The guidance does not suggest this is necessary.

7.8. The strategy discussion did not progress to a meeting where all information could have been shared. There was very little communication between professionals and no challenge to the Child and Family assessment that appeared to have not recognised the evidence base regarding domestic abuse, under ones' vulnerabilities, parental mental health, and substance misuse. The risk was not discussed or fully assessed.

7.9. Without full knowledge of all information the level of need was assessed as at Child in Need; this was again not challenged. A multi-agency Child in Need Meeting did not have all relevant professionals present and the recent threats to kill and Father being repeatedly at the house when he was not supposed to be were not escalated to a further strategy meeting and child protection level 4.

7.10. The domestic abuse pathway to harm appeared to be that a mother was struggling but had lots of professional support, was caring and attentive to her baby and professionals appeared to therefore not see the cumulative risk from the evidence-based knowledge that they were all aware of. Professionals did not see the level of concern because information was not shared; ultimately most

professionals relied on Mother to let them know what other agencies were undertaking.

7.11. Because of all of the above, the voice of Mira and what day to day life was really like for them was not heard and therefore opportunities to safeguard Mira from harm were missed.

8. RECOMMENDATIONS

The recommendations are built around the noted areas that require consideration of stronger practice.

1. Language Support

- KSCMP should seek to ensure that agencies' translation and interpreting guidance includes trigger points for where an interpreter should always be offered and/ or used e.g. safeguarding and domestic abuse.

- Guidance should also include that family and friends should not be used unless in an emergency.

- Record audits should have a field for evidence of use of interpreter where required.

2. Cultural Competence

- In recognition that Equality and Diversity and Cultural Competence have different applications for the workforce, KSCMP should source readily available free training for agencies to use to ensure that the workforce understands the difference that cultural competence makes to working effectively with those from different cultures.

- KSCMP should source or create a leaflet for staff that will aim to increase the specific Eastern European country's cultural knowledge amongst professionals who work with people from that country in recognition that it is the largest ethnic group in the town; through doing so, improving professionals' engagement and understanding and thereby supporting cultural competence.

3. Fathers

- The newly introduced process for monitoring of outstanding recommendations from previous reviews should be expedited. This is in recognition that the same recommendations from a previous LSCPR should be applied to this review in respect of inclusion of Fathers.

4. Domestic Abuse: Escalation and cumulative risk

- Kent County Council Integrated Children's Services to consider reviewing support levels guidance to include the following:
    - A prompt for professionals to consider if there would be benefit in convening a meeting with the family and professionals when a case is held at level 2
    - A reminder of the importance to liaise with other professionals in a case to ensure a holistic understanding of risk and need

- ‘Open Access’ and ‘Early Help’ references to be explored in relation to the document to avoid workforce confusion, alongside clarity of referral pathways at levels 2 to 4

- KSCMP should develop a strapline for use in all agencies and training that recognises the need for professionals to be able to listen to parents but at the same time talk to other professionals such as **Listening to families is important; talking to other professionals is vital** or one with the same meaning**.**

- KSCMP, via a subgroup or task and finish group, should produce a 7-minute briefing regarding professional challenge of professionals and courageous conversations with families (Example Briefings made available). These should then be used in training, supervision and mentorship as well as being available on KSCMP website.

- KSCMP should seek to understand if there is any similar learning within DHRs locally or work being undertaken by the Domestic Abuse Partnership Board regarding assurance that victims of domestic abuse do not have expectations on them to be the sole protector of their child/ren. Relevant learning from this review should be shared with the Community Safety Partnership and the Domestic Abuse Board.

5. General Learning Briefing

- KSCMP should consider various methods of sharing the learning from this review e.g. podcast, video, etc. as well as the traditional learning briefing.

- A case study regarding Mira’s story/ case should be developed to support individual and team reflection and for use in single and multi-agency training.