Kent Safeguarding Children
multi-agency partnership

Child U

LCSPR Executive Summary

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1. Introduction.

1.1. In accordance with Chapter 4 Working together (2018 at the time), Kent Safeguarding Children Multi-agency Partnership (KSCMP) undertook a Rapid Review in 2020 following notification of a serious incident where a pre-school aged child had died from traumatic head injuries. The outcome was a decision to undertake a Local Child Safeguarding Practice Review (LCSPR), which was agreed by the national Child Safeguarding Practice Review Panel.

1.2. Child U was a child of Asian nationality and came to England in 2019 with someone who claimed to be their adoptive mother. Child U lived with, who they considered, their two older siblings, mother and father, none of whom were biologically related to them. A new baby was born three days before Child U died. The family members are referred to as Mother, Father, and Child 1, 2 and 3 for the purposes of this report.

1.3. The review focussed on the family circumstances and multi-agency practice between April 2019 and May 2020, prior to U's death, including reference to whether ethnicity and culture impacted on the way services were delivered.

1.4. Further to completion of the LCSPR by independently commissioned consultants, this Executive Summary for publication provides a brief context of the family's circumstances and response by agencies at the time, highlights key learning themes and action taken since the incident, and makes further recommendations to KSCMP for it to continue embedding improvements in safeguarding practice.

1.5. The methodology for the LCSPR was impacted by the onset of the Covid-19 pandemic, therefore, this Executive Summary has fact checked the report produced in 2020 for publication.

2. Brief history of the family and agency response.

2.1. Child U lived with who they considered their two older siblings; Child 1, aged 10 years and Child 2 aged 4 years. Children 1 & 2 are the biological children of the parents. Father was referred to in

agency reports as Child U's Stepfather. Father was already in the country when his wife and the children arrived as he had been given refugee status. Child U was reported to be aged 21 months when they arrived in the UK.

2.2. It is reported Mother initially told professionals Child U was her husband's child, but not hers. She later retracted this and said Child U had been adopted by her without her husband's knowledge. Mother then said Child U's birth mother died in childbirth, and their birth father was unable to care for them. Attempts were made by Integrated Children's Services (ICS) to clarify this and during court proceedings after Child U's death it was determined with the relevant Embassy that the adoption was unofficial.

2.3. The family were known to a number of agencies, including a local GP, local community health visiting service, acute midwifery service, a school, a nursery, a mental health charity and the British Red Cross (BRC). These services were involved with the family within the timeframe of the LCSPR.

2.4. The family's involvement with the BRC was significant. The BRC had the first interaction with Father who sought their help to relocate his family to the UK. The BRC held valuable information relating to the family and their needs, which was critical to planning a response by the statutory sector.

2.5. Child U, Mother, and Children 1 & 2 arrived in April 2019 and began seeking a school and nursery place the following month. There was initially a delay in finding a school place for Child 1 who started at a primary school in September 2019, moving to another primary school in October 2019. Child 2 began attending nursery from November 2019 for one afternoon a week.

2.6. The family were known to a local health visiting service from May 2019. All mandated contacts were made with an interpreter. All the children were considered as part of assessments regardless of their ages. Although domestic abuse was discussed at some contacts, the questions were asked in front of the children and there was not always a rationale recorded when domestic abuse was not asked about. The health visiting records document phone calls and joint visits with the Social Worker and most of the Child In Need (ChIN) meetings being attended, although do not reflect invites to all However ICS information reflects that health visiting were invited to all and apologies received when service not able to attend.

2.7. Child U and their family became known to ICS in April 2019, following a referral (Request for Support – RFS) made to their Front Door Service (FDS) by the BRC on behalf of the family who were seeking housing and financial assistance.

2.8. The RFS was triaged and the family allocated to an Early Help Worker for support to integrate into the local community.

2.9. In June 2019, the police made a RFS to the FDS regarding domestic abuse perpetrated by Father to Mother. Child U and Children 1 & 2 were seen by an Out of Hours social worker and a Strategy Discussion was held the next day, resulting in a Section 47 investigation. Father was arrested and bailed not to enter the area where the family were living, or to contact Mother or the children directly

or indirectly. When Child 1 was seen by the Out of Hours Social Worker, they described experiencing physical abuse by Father, witnessing domestic abuse and stepping in to protect their Mother.

2.10. At the Outcome Strategy Discussion Out of Hours ICS and the Police determined there were ongoing concerns regarding domestic abuse with the children in the home at continuing risk of significant harm. A decision was made to continue with a Child and Family assessment to identify what support was needed and Mother's ability to remain separated from her husband, with ongoing consideration of the risk of significant harm to the children and the need for a Child Protection Plan. Information was shared by Police to ICS regarding a voluntary sector organisation that can assist women from abroad who are experiencing domestic abuse in the UK, however, it is unclear if this information was shared with Mother.

2.11. A Domestic Violence Prevention Notice (DVPN) and afterwards a Domestic Violence Protection Order (DVPO) was issued against Father in July 2019 as it was noted he had breached his bail conditions by returning to the family home. He was arrested after the Independent Domestic Violence Advisor (IDVA) called the police, having heard a male voice in the background whilst on the phone to Mother. Mother confirmed she had been assaulted but did not wish to pursue a prosecution.

2.12. Father breached the DVPN for a second time when he attended the housing office with Mother and the children. A warrant was issued for his arrest, and he later appeared in court. He received a custodial sentence until the expiry of the DVPO 5th August 2019, at which point he returned to the family home.

2.13. The Child and Family assessment was completed end of August 2019; whilst child protection procedures were considered, it was decided the family would initially be supported under ChIN arrangements given recent stability seen and parents' agreement to engage.

2.14. Days later, neighbours reported seeing Father assault Mother. The police were called and during this attendance they noted the children were dirty, there was no food in the cupboards and there were no clothes or toys for the children. There was known tension with neighbours and Father suggested the report was malicious. However, Father was arrested.

2.15. As a result of the alleged assault, the social worker spoke with Mother who denied she was assaulted and claimed her eldest child was hurt by a police officer. There was no presenting evidence to support the alleged injury to Child 1 by the police.

2.16. A ChIN meeting was held in September 2019. The meeting was attended by ICS, Housing, the Health Visitor, the British Red Cross (BRC), Mother and Father. The ChIN plan identified a range of needs and service interventions to help and support the family, including work with both parents to understand the impact of domestic abuse on children. Support for Mother as a victim of domestic abuse and practical input to address the family's housing difficulties and financial needs were also part of the plan.

2.17. The following month, Child U was admitted to a local hospital and transferred to a specialist London Hospital with severe burns. It was reported Child U had tripped over a kettle that Mother was boiling

on the floor for the children's baths. Father was reported to have arrived home after the accident, which occurred at 0100 hours

2.18. Safeguarding concerns were communicated by staff in the local Accident and Emergency department via a safeguarding notification to the Hospital Safeguarding team.

2.19. A Strategy Discussion took place the next day. The medical view discussed at the Strategy Discussion confirmed the injuries were consistent with the explanation given. Nursing staff reported observing Father to be attentive and appropriate with Child U during their stay as an inpatient. Practitioners at the meeting took the view that the medical opinion that the burns were consistent with presenting history given by the parent meant there were no concerns about non-accidental injury. A police investigation was not considered necessary; however, a single agency ICS Section 47 (S47) enquiry was commenced due to the severity of the injuries sustained by Child U.

2.20. Child U was discharged from hospital a week later and an outcome Strategy Discussion was held.

2.21. As part of the Strategy Discussion and S47 enquiry, the lack of hot water and heating due to the gas meter being broken in the home and a lack of supervision were considered the key factors leading to Child U's injuries. The S47 investigation therefore concluded, "concerns are substantiated, but the child/young person is not judged to be at risk of continuing harm." Mitigation plans were put in place, specifically; liaison with Housing to address the hot water issue, and a plan was identified to offer social work assistant input to address home safety measures with parents.

2.22. In November 2019, Mother was seen in the street by a social work assistant. Mother was crying and had a nosebleed and graze to her hand. The social work assistant spent time with Mother, however, she did not disclose how she sustained her injuries.

2.23. The social worker visited Mother at home with a health visitor shortly after. Mother continued to deny domestic abuse. The social worker was concerned about domestic abuse, and that Mother would not disclose this to her directly. During this visit Mother also confirmed she was pregnant, which was unplanned.

2.24. A social work assistant attended the family home in late November 2019 to complete the home safety work. Child U was seen during the home visit and it was noted they were ill and sat quietly on Mother's lap for the whole visit. The burns to their legs were healing.

2.25. In December 2019, a planned ChIN meeting did not go ahead due to lack of interpreter availability, however, a separate prearranged meeting occurred involving the social worker and the BRC. This was because the BRC wanted to share concerns in a face-to-face meeting that Mother had disclosed a week earlier about verbal abuse by the children's Father towards her and the children. BRC were advised to tell Mother they had shared this information with ICS and a week later the social worker visited the family but was unable to discuss the concerns due to the Father being present.

2.26. During an unannounced visit to the social care offices in early January 2020, Mother shared details of historical physical abuse and stated things were currently much better. A ChIN meeting followed 2 days later.

2.27. The following week, a BRC worker contacted the social worker via telephone and email to advise that Mother had disclosed a physical assault by Father. Whilst BRC say Mother shared about a possible rape, there is no evidence this information was shared with the police or the social worker at the time. The BRC worker reported seeing bruises on Mother's arms, bites on her hand and red marks on her head. The family were visited the next day by a social worker, however, Father was at home during the visit and there was little opportunity to explore the disclosure in any detail with Mother. It was hoped that Mother could be spoken to at the BRC offices 5 days later by the social worker. As planned, the social worker attended BRC offices to meet with Mother, however, Father and the children also arrived for the appointment. Approximately one-week later BRC completed a professional's referral to MARAC.

2.28. A social worker and health representative attended the MARAC meeting in February 2020; an action was suggested by the Chair to hold a 'professionals meeting' to consider how best to engage Mother.

2.29. On the same day as the MARAC, a home visit took place by the social worker, during which Mother was asked about a small bruise noted on U's cheek earlier that week. Father explained that Child U's bruising occurred whilst playing with one of their siblings. The social worker considered the account was consistent with the bruising. Child U was asleep in their pushchair during this visit.

2.30. The same month, police received a call of concern by neighbours. This was followed up by the police, however, it did take a few days before Mother was successfully seen. There were no allegations or concerns raised regarding the children. It is unclear if they were spoken to and ICS have no evidence of this information being shared with them at the time.

2.31. In March 2020, the social worker attempted a home visit following a report from school that Mother was seen with an eye injury. There was no answer at the home address.

2.32. During a home visit the next day, the social worker discussed the injury. The social worker did not observe the bruising that the school had reported. Mother also explained that U had scratched their face on a bush when she had picked them up. During the visit U was seen in the kitchen having breakfast.

2.33. The planned professionals' meeting recommended by the Chair of MARAC took place in March 2020. The police gave apologies to the social worker for not being able to attend and noted they had asked the BRC, following MARAC, for written information on the initial disclosure by the Mother and to encourage her to speak to them. The meeting was attended by the social worker, school, midwifery, the BRC and a mental health charity, and discussed concerns including missed appointments and domestic abuse. The plan identified a range of support to be offered to Mother. The social worker advised in the meeting that escalation to child protection procedures would be considered should there be any further disclosures of domestic abuse. In line with the Domestic Abuse Act 2021 and local procedures, if concerns escalated, a further disclosure would not be required to pursue a child protection section 47 inquiry within practice currently.

2.34. A ChIN meeting took place the same day immediately after the professionals' meeting with the same professionals, and Father and Mother. The new worries about domestic abuse occurring were not discussed in the ChIN meeting. Father continued to say there was no proof of domestic abuse and only allegations. Father shared he did not think the ChIN meetings were helpful and repeated this in a phone call with the social worker the following day. Father was reminded the meetings were used to consider if the children were safe and the risk of harm reduced.

2.35. COVID-19 restrictions came into place during March 2020. U, and Children 1 & 2 were seen in person on two occasions by a social worker in early April and early May 2020 with social distancing measures in place in the family's garden. There were several attempted telephone contacts made after this, but many were not responded to. Text messages were sent several times by a social work assistant to Father's telephone.

2.36. Mother gave birth to Child 3 in May 2020 and was discharged the next day at 1730. Out of Hours (OOH) ICS were informed of the birth by midwifery and discussions took place regarding a discharge planning meeting. It was agreed the midwife would speak to Mother regarding Father and any concerns about going home, and would review the safety plan with her and update OOH. It was agreed that midwifery would call OOH ICS for a telephone discussion and sharing of information 2 hours prior to discharging home, which was planned for the next day. When OOH called back to clarify about the requirement for a discharge meeting the midwife shared this was referred to in an email from the social worker to the hospital safeguarding team, following a MARAC meeting. Whilst OOH could not find the required detail on file, they concluded a safety plan was required. The following day Midwifery shared with OOH they spoke to Mother who reported the children were safe and she had no concerns. OOH then spoke to each parent individually with an interpreter, sharing the concerns and confirming the safety plan. The hospital agreed to arrange for the community midwife to be appraised and to visit the next day. An email was sent to the case holding team and a case note recorded for the team manager to follow up on the contact with OOH.

2.37. Two days following Mother and Child 3's discharge, Child U was taken to the local hospital by Father in an unconscious state with a fractured skull and a subdural bleed.

2.38. It was reported by Father that U fell down the stairs while he was absent from the home. During examination at the hospital, an older subdural bleed was identified, as was an old fracture to Child U's right humerus. A fingernail was also found to be missing. These injuries were considered to be unexplained.

2.39. Child U was transferred to a specialist London hospital for neurosurgery. Their injuries were described as life threatening and were likely to have occurred up to 12 hours prior to presentation at hospital. The Local Authority was notified by the hospital that Child U was gravely ill, their clinical status deteriorated and the decision to withdraw intensive care was made. Child U died with Mother and Father at their bedside.

3. Analysis and learning

3.1. **Domestic Abuse**

3.1.1. Mother is said to have reported, 'He (Father) was no longer physically abusive, but was verbally abusive to the children and her' and there were instances physical injuries were observed on Mother by professionals. There was an overreliance on Mother's self-reporting and domestic abuse risk assessment and planning being left to the police.

3.1.2. The extent and severity of the domestic abuse seemed to be overlooked. It is unclear if this is due to an over reliance on self-reporting as a definition of domestic abuse, or focus was often on cultural assimilation and practical support for the family. There were opportunities when asking further questions that may have helped understand Mother's perspective on the situation, for example, when she said, "if I am not safe at home, where would I be?"

3.1.3. ***Learning:*** *The multi-agency network around the family would have benefitted from triangulating information in response to domestic abuse at the time, whilst appreciating that individuals will not disclose all or consistently to every professional when asked about domestic abuse. Denying domestic abuse to a professional does not mean it is not happening and what is shared can depend on the relationship with the individual. All agencies need to have training available to staff around recognising and responding to domestic abuse, including understanding its dynamics and immediate safety planning measures. KSCMP offer multi-agency training titled 'Understanding domestic abuse and effects on children'. This has been designed for frontline practitioners working with children and families. There is also Domestic Abuse guidance available on the KSCMP website.*

3.1.4. It is documented that in August 2019, Mother shared that Child 1 intervened in an incident of domestic abuse against Mother by Father, during which they were pushed by Father causing them to fall, hitting their head. It was significant for a small child to intervene in an adult altercation and an indicator the children were experiencing violence on a regular basis.

3.1.5. It was recognised some practitioners were aware that Mother was experiencing domestic abuse. The BRC were concerned from their observations and direct work about Mother's ability to protect herself and the children and shared this to multi-agency partners in referrals to MARAC, in writing, and in meetings, however, it is unclear if MARAC considered impact on the children.

3.1.6. ***Learning:*** *Agencies must recognise children are victims of domestic abuse and may intervene in incidents. When reports of this are made, ongoing safety must be fully risk-assessed and the impact of domestic abuse on children explored with the family. Domestic abuse always has an impact on children, and the more recent Domestic Abuse Act (2021) now recognises children as victims, not witnesses, if they "see, hear or otherwise experience the effects of abuse." (Chapter 17, Part 1[1])*

3.1.7. A multi-agency professionals meeting was held following the MARAC in March 2020 to consider how best to approach Mother given risk this might place her in. Mother was spoken to by a social worker away from Father, with Child U present. She denied any domestic violence, and though

[1] Domestic Abuse Act 2021

professionals' concerns were reiterated to her, she insisted no assaults or abuse had occurred. Furthermore, when the health visitor made enquires with Mother about domestic abuse she denied any within the relationship.

3.1.8. ***Learning:*** *There were several MARAC meetings that took place, however, little evidence of improving outcomes. Concerns highlighted should have required actions being allocated to multi-agency partners, however, evidence of allocation is limited and there seemed to be no process to follow them up. In 2022 the Kent MARAC model was reviewed and a new model co-designed. The new model is based on quick information sharing and agency accountability to enable a more proactive approach to reducing risk.*

3.2. **Cultural competence**

3.2.1. Every person and family's needs should be considered and assessed in the context of their social and cultural norms and beliefs.

3.2.2. There were difficulties when working with interpreters, for example, gender sensitivity for Mother as an antenatal patient created barriers. There was also an incident when an interpreter assisting the BRC refused to repeat an abuse disclosure in Mother's own words, which would have diminished its impact.

3.2.3. ***Learning:*** *Consideration should be given to the cultural needs of individuals and using gender appropriate workers and interpreters. It is unclear in this case whether interpreters used had the training, support, or were willing to work specifically with sensitive issues and topics. Cultural Competence and Unconscious Bias training was commissioned for Kent professionals as a result of Child U's death and remains available. A fact sheet was also produced.*[2]

3.2.4. There was some suggestion of unconscious bias leading to housing and safety issues being accepted without substantial challenge by visiting professionals who perhaps assumed these were expected living conditions for refugees, although following one of their visits, the police did report concerns about the unkempt state of the children, lack of food and lack of child focused stimulation by way of appropriate toys.

3.2.5. While attempts were made to engage Mother in community groups, the reality for her was perhaps that a language barrier, her role in the family, and domestic abuse impacted her independence, confidence, resilience and ability to accept these options.

3.2.6. The family said they experienced racist abuse from their neighbours and reported being fearful and deeply disappointed with their refugee experience, location, and accommodation. These stressors were reported to police, but it is unclear if realistic multi-agency actions and goals were considered or clear in relation to the family's physical and mental wellbeing.

[2] Cultural bias and competency

3.2.7. ***Learning:*** *Every person and family's needs should be considered and assessed in the context of their identity and experiences, and whether what they are reporting about that is influenced by additional factors such as domestic abuse.*

3.2.8. Insufficient weight was given to the lived experience of the children or to the past trauma and experiences of Mother and Father in Asia prior to and whilst leaving their country of origin. There was a lack of awareness in practice regarding the impact of trauma and how the refugee experience can lead to Post Traumatic Stress Disorder (PTSD) or other mental health issues.

3.2.9. ***Learning****: Agencies should use a trauma informed/healing centred approach to assessment to gain an understanding of an individual or family's circumstances and experience. Trauma informed/healing centred practice should consider realistic multi-agency actions and outcomes in relation to individuals physical and mental wellbeing to support positive outcomes. Further to Child U's death, work has taken place in Kent with regards to trauma informed care and a healing centred approach to ensure that all family history is taken into account when delivering support to a family. Following the death of Child U, KSCMP offers multi-agency trauma awareness e-learning. More recently, as part of the updates to Kent Practice Framework, a key component is the use of Healing Centred approach across the safeguarding partnership.*

3.3. **Working together, services' capacity, and demand**

3.3.1. From the time Child U arrived in the country with Mother and Children 1 & 2, there was involvement with various agencies including NHS services, ICS, Police and the BRC. The family were referred to other agencies for specific help, with varying degrees of success based on engagement. Contacts were typically a combination of face-to-face and via telephone, and for the majority, an interpreter service was used. The nature of this support inevitably changed when the COVID-19 pandemic was declared.

3.3.2. Steadily accumulating over many weeks were mounting concerns, including reports of abuse by the family and neighbours, injuries sustained and observed by professionals, and situational harm. Positive changes in the behaviour and circumstances of the family were not reported. Within multi-agency meetings there were suggestions the child protection threshold was met. BRC also raised concerns directly with ICS.

3.3.3. Information regarding the risks to Child U and the other children in the home was documented within records, however, information did not appear to have been analysed and considered in accordance with the balance of probability or the likelihood of significant harm occurring to the children.

3.3.4. ***Learning:*** *Professionals should use chronologies to effectively map cumulative harm and other concerns, and any positive change. This can support onward referral, decision making, and effective escalation where appropriate. Professionals should familiarise themselves with the Kent Escalation and Professional Challenge Policy.*

3.3.5. Health professionals reported anecdotally to the Independent Reviewers a positive account of working together arrangements in their area, including information sharing. This friendly regard and high level of trust in the system may have affected the willingness and ability of partner agencies to challenge each other, enquire, or formally escalate matters when plans were failing to achieve required change.

3.3.6. ***Learning:*** *All professionals must be able to participate and contribute as equals in multi-agency contexts, and effectively challenge decisions and actions they believe might not be in a child's best interests. This responsibility is impacted by the nature of local relationships. Multi-agency expertise must be proactively encouraged and properly incorporated into the ChIN process, which should be coordinated but not dominated by the Local Authority. It is important all agencies contribute to triangulation and scrutiny of information and are confident and able to question each other, which is a sign of a healthy safeguarding system.*

3.3.7. The Kent Safeguarding Children Multi-agency Partnership Arrangements (December 2024), recognise that by working together across different organisational boundaries and in partnership with other public sector bodies, and voluntary and community sector organisations, we can provide the most effective support. As a part of the arrangements, a communications strategy will be developed with Voluntary, Charity, Social Enterprise organisations and sports clubs, to highlight local pathways for guidance and referrals regarding safeguarding concerns.

3.3.8. Various professionals shared abuse concerns to multi-agency partners, though the perception of the BRC was that the weight their information and expertise carried was less than that of statutory agencies, despite having valuable knowledge of the family's needs and a different type of relationship with them e.g., Mother was prepared to share sensitive information to BRC workers that she was more reluctant to with statutory services. Statutory agencies investigating reports of abuse found some challenges in the clarifying of information from other agencies.

3.3.9. There is evidence of multi-agency partners working together at Strategy Discussions, ChIN meetings, professionals' meetings and joint visits to the family to effectively assess need, risk, and to deliver support. However, it appears ChIN meetings mainly consisted of updates or actions for the Chair to pursue rather than sharing actions with the multi-agency network.

3.3.10. ***Learning****: ChIN assessments and plans safeguard and promote the wellbeing of children, with all professionals working with a family expected to contribute. There is a shared responsibility to define goals and measure outcomes that reflect an improvement in a family's situation. Since the death of Child U work has been undertaken by ICS to improve effectiveness of ChIN meetings, with guidance, training, updated agendas and greater awareness of the need to involve third sector organisations.*

3.3.11. In March 2020, following a three-month period of no reported abuse by Mother or Child 1, Father was requesting case closure to ICS. However, parents were encouraged to remain on a ChIN plan, and although BRC did not agree, other agencies agreed the threshold was not met to escalate to child protection at this point. It was noted that the social worker would meet the family to discuss

proposed timescales for ongoing intervention and consideration would be given to escalation where appropriate if agencies had new concerns.

3.4. **Voice of the Child**

3.4.1. At the time Child U was seriously burned they found themselves living in a house that required repairs and had no hot running water. They were sleeping with their parents and siblings in one room, on mattresses on the floor. The boiling kettle was being used as a source of hot water to wash them with at midnight. Child U was taken to hospital and required inpatient treatment in a specialist unit for what must have been a very painful injury. Within the subsequent referral to ICS and two Strategy Discussions, there is limited information showing consideration and professional curiosity about the lived experiences for Child U and their siblings and the impact on them.

3.4.2. ***Learning:*** *Even if an injury is considered to be accidental, professionals should be curious to understand whether the child is living in a safe and protective environment and if that environment has contributed in any way to the harm.*

3.4.3. The older children attended school and nursery provisions locally until the COVID-19 restrictions led to them being kept at home. This was further change for them after routines and new relationships were beginning to be established following their move to a new country and meant fewer professionals were seeing them regularly to gain an accurate understanding of their personalities and lives.

3.4.4. It is likely the children's language skills at this time could also have made establishing this picture more difficult for professionals, who would have been more dependent on observational skills in relation to child development, behaviour, and trauma.

3.4.5. It is likely the children were experiencing violence and aggression in the home perpetrated by Father, as evidenced by Child 1's intervention during an attack on Mother. This must have been very frightening for them. There is much available research on the impact of domestic abuse on a child's lived experience and professionals should remind themselves of this.

3.4.6. ***Learning:*** *Whilst communication difficulties, disabilities, the age of a child and abuse can all complicate understanding a child's lived experience, it is imperative that professionals consider a child's life through their eyes. Partners have worked on how this can be evidenced since Child U's death, including observing children in multiple settings, and in ICS, writing to the child on file and in reports to help professionals reflect on what is being seen, said, unsaid and the likely impact.*

3.5. **Father Inclusive Practice**

3.5.1. Father had experienced serious and traumatic events in his previous country which has been a warzone for several years. He was treated by his GP for anxiety and mental health issues since his arrival in the UK. There appeared to be limited understanding of how Father's physical and mental

health needs might affect his parenting ability and functioning of the family, and how this could be supported was not adequately reflected in the ChIN plan.[3]

3.5.2. When agencies were trying to ascertain how Child U came to be a part of this family, finding out more regarding Father's views on this could have identified issues requiring support, e.g., with establishing a relationship, attachment, or ability to provide for basic needs.

3.5.3. ***Learning:*** *A lack of father inclusivity has been cited as a factor in national and local child safeguarding practice reviews. Inclusion of fathers is an essential element of practice with children and families to ensure wellbeing and safeguarding needs and risks are properly understood. Since this case, Kent has produced Father Inclusive Guidance and accompanying resources to support practitioners and service providers in taking an inclusive approach to engaging fathers.*[4]

3.6. **The impact of Covid-19.**

3.6.1. Strict COVID-19 measures were in place when Mother was in the third trimester of her pregnancy with Child 3 and continued after the birth in May 2020. Children 1 & 2 were withdrawn from school and nursery when the restrictions were applied, although the school maintained contact with the family.

3.6.2. In order to control community transmission of the disease, social and healthcare professionals who had previously supported children and families by means of home or office visits were expected to offer on-line only support where at all possible.

3.6.3. Following National Guidance, the Local Authority undertook a rag-rating of cases similar to that described in the Social Work England best practice guidance. The process was to determine case-work priorities according to their needs. A 'Red Rating' indicated a significant risk of serious harm, injury or death and required a home visiting programme, 'amber' signified moderate risk of either emotional or physical harm and neglect, and 'green' was applied to children at low risk of harm or neglect.

3.6.4. This family were rated as 'amber' at the beginning of the lockdown period, and this did not change prior to U's death. The family were visited in April and May 2020, with due regard to social distancing measures. This was to acknowledge the complex needs of the family, and their difficulties with communication. There were two visits on one day in May. The first undertaken by the allocated social worker which consisted of standing in the garden with Child 1 and 2, Child U was said to be asleep. The second by a Newly Qualified Social Worker (NQSW) who was not the familiar person the family had a working relationship with. On this visit Child U was apparently having a wash so Mother held them to the window.

3.6.5. ***Learning:*** *Much has been learnt about the impact of COVID-19, including the adverse effects on vulnerable children and families. Updated guidance from the Department of Education has been*

[3] There are some learning parallels here with Kent's LCSPR Iman

[4] Father Inclusive Guidance - Kent Safeguarding Children Multi-Agency Partnership

issued with regards to the importance of dynamic critical risk assessment and close observation of children with complex needs during restrictive pandemic arrangements.

3.6.6. There is evidence of both face to face and telephone appointments during the antenatal and post-natal period that occurred during lockdown. There was dialogue between Children's Social Care and the midwifery unit at the time of discharge from the hospital and a safety plan agreed. OOH were informed of Child 3's birth and that midwifery records indicated a discharge planning meeting was to be held. However, OOH could not see evidence of this on the file, or a copy of a discharge plan by the midwife and social worker, this would be expected 6 weeks prior to birth if agreed as part of the pre-birth assessment if significant risks are identified.

3.6.7. ***Learning*** *– Subsequent work has been undertaken regarding pre-birth assessments, discharge planning and risk assessment. ICS have conducted deep dive audits to measure the embedding of improvements and additional updates are currently being made to procedures.*

3.7. **Establishing Parental Responsibility.**

3.7.1. BRC shared that their process of family reunion has been updated to be more robust, there are now more questions for those interviewing a family, so it is clear whether there is a full biological relationship or an adoptive relationship. This can also consider whether DNA testing is required in certain cases.

4. Recommendations.

4.1. Where the Partnership has already taken action in respect of learning arising from the circumstances of Child U's death, it has been referenced within the body of this Executive Summary.

4.2. Since 2020 there have been actions taken in respect of subsequent safeguarding reviews by the Partnership. The recommendations below reflect key learning identified and requiring further action, having fact-checked the original report.

4.3. **Recommendation 1:** Kent Safeguarding Children Multi-agency Partnership to create an easy reference document, with links to training and guidance on key issues identified within the learning, including:

- Children as victims of Domestic Abuse
- Cultural competency
- Lived experience of adults and children to include voice of the child
- Father Inclusive Practice
- Multi-agency Domestic Abuse training
- Escalation and Professional Challenge policy

Recommendation 2: Kent Safeguarding Children Multi-agency Partnership to share the new MARAC process to all agencies once the dedicated MARAC launch edition newsletter has been published.