Local Child Safeguarding Practice Review

A THEMATIC REVIEW FOR TWO CHILDREN KNOWN AS DIALLO AND KATIE

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1. Introduction and scope of the review

1.1 This Child Safeguarding Practice Review (CSPR) was commissioned by the Durham Safeguarding Children Partnership (DSCP) to consider systems and practice within and between partner agencies in the Durham area. The review will consider two children where similar themes were identified within a three-month timeframe. Following the rapid reviews [2] and consultation with the Child Safeguarding Review Panel, it was agreed that a thematic CSPR would be undertaken to consider learning from both children. Thematic reviews can review broader aspects of practice where for example there were issues in more than one case.

1.2 Neither family were involved with statutory services and the rapid reviews considered some similar matters around children accessing universal services, cross-boundary working, professional curiosity and information sharing.

1.3 The children at the time of the incidents were three years and under. Due to the limited information about the families and to support understanding of the children's lived experience the scoping period included known information from birth.

1.4 This meant the timeframe now included the period of national lockdown between March 2020 and March 2021. Other contextual issues included a self-referral to the Independent Office for Police Conduct (IOPC)[3] regarding the request under Claire's law[4] by Katie's father. There were identified local and national pressures in the recruitment and retention of health visiting staff and features of this review reflect local strategies to manage this. This included reviewing the skill mix of the workforce to recruit less experienced staff to manage children in the ***universal pathway*** (See diagram 3 page 10) the employment of agency staff or enabling current staff to take on additional work. What was referred to at the time as a 'vacant caseload' (currently named a 'waiting list') was a process where all children on the universal pathway[5] were provided with a health visiting service to ensure service delivery to meet demands. In the context of this review, it accounted for the high number of health visitors and child health professionals involved with both families.

1.5 Summary Learning

The following key learning points are detailed and analysed in the report and summarised here

- Strengthening respectful enquiry and critical thinking across the workforce
- The importance of 'whole family' practice where there are adult issues likely to impact on children's needs
- The role of fathers, family relationships and men introduced to the household. Service responses to domestic abuse and separated fathers.

[2] A Rapid Review is undertaken in order to ascertain whether a LCSPR may be appropriate, the decision is made alongside the National Child Safeguarding Review Panel

[3] Independent Office for Police Conduct – investigates complaints and allegations against the police https://www.policeconduct.gov.uk/

[4] This enables the police to disclose information to a victim or potential victim of domestic abuse about their partner's or ex-partner's previous abusive or violent offending. Information Sharing (proceduresonline.com)

[5] Health visiting and school nursing service delivery model - GOV.UK (www.gov.uk)

- Recognising opportunities to provide timely preventative early help support across adult and children's services
- Routine enquiry and consideration about all the children in the household should be made and where they are so they are visible to services
- Understanding the impact of families that move frequently on accessing services across geographical areas and the increased stresses this can present, particularly for new parents
- Pathways to share information between non-emergency medical care and community services and strengthening the coordination of this preventive early support.
- Developing confidence and knowledge across the workforce about race, culture, religion, and aspects of parenting.

2 Review Methodology

2.1 The Review Group agreed on the methodology and process (Terms of Reference) for the thematic review, developing questions and had oversight of the progress of the review. Consideration of these two children thematically would enable a focus on the systems and practice in place, identify strengths and identify learning for the system and multi-agency practice. The review approach was reflective, proportionate, and sought to avoid hindsight bias or individual blame. The analysis utilised frameworks that help us to understand risk and vulnerability.[6] Chronologies and information were provided by agencies and frontline staff and their managers were involved in separate practitioner learning events to capture individual child experiences.

2.2 The key lines of enquiry were formulated by the LCSPR review group and framed as questions for each of the learning events. The limited knowledge about each of the children from services meant some of these questions could not be fully explored. DSCP made efforts to seek information from the Local Authority areas /Partnerships that one of the families had lived in, this was provided but provided limited additional information. The families were not known to statutory services apart from some historical information regarding the maternal family of Diallo when mother was around 14 years old and concerned an incident of physical abuse by maternal grandmother using a belt on Diallo's mother. This resulted in a short period of intervention at the time by social care where an assessment and parenting support were provided. This was not known until after the significant incident.

2.3 For the purposes of this CSPR the children will be known as Diallo and Katie.

2.4 A reflective conversation was held with Diallo's nursery who were not able to be at the learning event, and professional conversations held with senior colleagues responsible for the delivery of health visiting services.

[6] Pathways to harm , Pathways to protection https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/869586/TRIENNIAL_SCR_REPORT_2014_to_2017.pdfhttps://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/869586/TRIENNIAL_SCR_REPORT_2014_to_2017.pdf

3 Relevant family and child backgrounds

3.1 **Diallo** was a Black British African male 3 years old at the time of the significant incident[7]. He lived with his younger brother and both parents, at the time of the incident father was living away undertaking a training course. Diallo was taken to hospital by ambulance after his mother reported him unresponsive after choking on some food. Despite medical intervention he died, after his death, he was found to have a fatal head injury, significant bruising, extensive burns, scabs, and a black eye. There were signs of trauma and neglect. Mother was arrested and charged with murder; criminal proceedings are ongoing. There was no involvement from statutory services, the family accessed universal services from Health Visiting, General Practice, and private Nursery care for a short period. It became known at the rapid review that the family had lived in three local authority areas and Diallo had spent lengthy periods in the care of his maternal grandmother out of the area. Following the incident, questions about mothers' cultural and religious beliefs regarding parenting and health care were raised.

3.2 **Katie** was a White British female 2 ½ years old at the time of the significant incident, she was an only child. Katie experienced an abusive head trauma, had multiple bruising, and died as a result of her head injury. Mothers partner was charged with murder, mother was also arrested for causing or allowing the death or suffering of a child. Criminal investigations are ongoing. At the time of the incident Katie lived with her mother and her mother's partner, this was a relatively new relationship of some 11 weeks, there was no involvement from statutory services, and the family received universal services from Health Visiting, General Practice, and Nursery care for a short period. Information shared at the Strategy meeting following the incident showed that mother's partner was known to a neighbouring authority through his children (not living with him). Katie's parents had separated, prior to this father was said to be the main carer while mother worked. Katie experienced four house moves, and three when living with both her parents. Eight months after the parents had separated Father contacted Durham First Contact service[8] requesting information about mother's partner who was living with his daughter, and he was advised to speak to the Police. Whilst father spoke to the police the disclosure did not progress.

4 Family Engagement

Families' views are integral to LSCPR's, Working Together 2018 and is best practice [9] There are ongoing criminal proceedings in relation to both children and it has not been possible to find a solution that would enable the lead reviewer to speak to family members. This means that gaining an understanding of the

[7] The process by which local authorities notify incidents that meet a clear criteria detailed. Working Together 2018) Report a serious child safeguarding incident - GOV.UK (www.gov.uk)

[8] First Contact is Durham's multi agency service where concerns about a child welfare are made. It provides help, guidance, and support. Calls are initially screened by a trained call handler and decisions are made about the level of response and support needed by the multi-agency team

[9] Serious Case Review Quality Markers – SCIE [9] Rights, Responsibilities and Pragmatic Practice: Family Participation in Case Reviews. Morris, Barndon, Tudor (2013)

families and how services may have supported them is more limited, particularly as there is very little information held and known by services about the families and any support networks they may have had.

5 Thematic analysis and identification of key learning

5.1 The following themes emerged and were used to analyse the information across the partnership and direct knowledge from those services involved with the children and their families. This has informed an understanding of the multi-agency responses in these instances and the circumstances leading up to the significant incidents. Relevant learning is identified and applied directly to practice and system improvement.

Themes
Knowing the children and understanding their experiences
Cross-boundary working and information sharing
Professional curiosity and critical thinking
Race, ethnicity, and culture (Diallo)

Knowing the children and understanding their experiences

5.2 Study of serious incident notifications by the Child Safeguarding Practice Review Panel[10] evaluated that most children who have died or have been seriously harmed were either involved with social care at the time of the incident or known to them. This review considers two children who were ***not*** known to children's social care but were known to *universal services*[11]. The abuse and death of the two children involved in this review will invariably raise questions about should they have been. However, there is a risk of applying hindsight bias and seeking to overestimate what could have been known or done particularly as most of the information about the children and families was only known after the incident. However, across both cases, there were opportunities or acute moments where some support may have helped the families, and these relate directly to predisposing vulnerabilities experienced by the parents around mental health, domestic abuse, and parenting experiences. Whilst these were hidden vulnerabilities and it is not reasonable to expect they were knowable or could be attributed to events, there were critical moments where the vulnerability around these issues *could* have been explored by different professionals. Opportunities to enquire further and offer support are identified in the review and relate here to knowledge and awareness of the impact of adult issues on children and family functioning.

[10] 2020 Child Safeguarding Practice Review Panel First Annual Report

[11] Universal services are services provided to all children and their families regardless of their needs or circumstances , for example health visitors, GP's schools and leisure and community services.

5.3 The review panel group was curious about what life was like for these children and wanted to consider any characteristics or experiences that could help understand the events leading up to their death. There remains limited information and details about their lives, however, both children attended nursery for short periods, and this has provided a direct sense of the children.

> "*Some children are hidden from statutory services and sometimes, whilst families were using a range of public services, the abuse is hidden. Often the serious incident seemingly came from nowhere, with no specific risk factors and no family involvement with statutory agencies. This brings into sharp relief the unpredictability of many deaths or serious harm in the context of child abuse."*
>
> (2020 Child Safeguarding Practice Review Panel First Annual Report 2019)

5.4 Whilst there was no historical information about parental histories the subsequent reflection supports important learning about the impact of parental histories and experiences upon their parenting. There were a number of predisposing vulnerabilities[12] for both children that included a number of house moves, changing main caregivers (particularly for Diallo), parental mental health, domestic abuse, parental separation, and parental histories. Diallo has had different family caregivers and has moved several times, not always with his family. (see diagram 1) There is some information that the relationship was unstable and a report of father disclosing domestic abuse to the police and additional periods of separation discussed later.

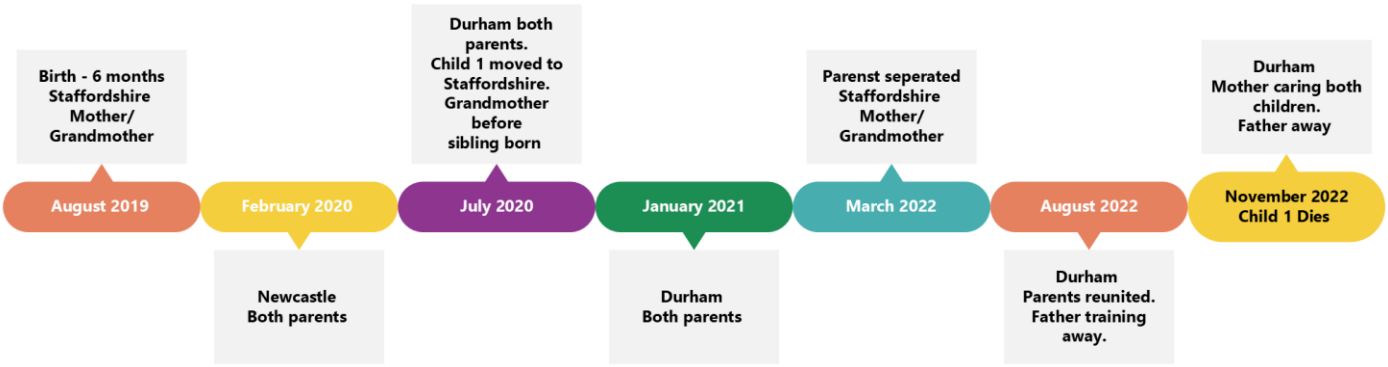
5.5 Information gathered after the incident showed that Diallo's mother was brought up in Staffordshire where she lived with her mother and adult sisters, and this was where Diallo spent the first 6 months of his life. Father lived separately in another area some 60 miles away. There is no information on home circumstances or father before Diallo moved to the area. No concerns were reported, and transfer notifications were made. There are no records from when Mother and/or Diallo returned to live with maternal grandmother, information obtained after the incident strongly suggested that maternal grandmother was controlling and was not open to him returning to his parents. It appeared she may have had more involvement and influence both directly and indirectly in the family life and care of Diallo. If there is no curiosity about the children's whereabouts and the family dynamics any potential support needs cannot be explored.

5.6 Dialo's parents subsequently married, and Diallo moved to the Northeast (Newcastle) with his parents and the family hoping to secure cheaper accommodation and living. They relocated to Durham some six months later when Diallo was nearly a year old. Mother was then pregnant with her second child and Diallo went to live with his maternal grandmother in Staffordshire in the month before his birth. Information suggests this was to provide family support. Diallo stayed in his maternal grandmother's care for some six months. It is noteworthy that this period was during the period of lockdown restrictions, and it is not clear what level of contact mother and father had with Diallo at this time. He had returned to Durham to be with his parents in early 2021. Just over a year later his parents separated, and his mother and both children returned to Staffordshire to live with their maternal grandmother. Within five months the couple had resumed their

12 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/869586/TRIENNIAL_SCR_REPORT_2014_to_2017.pdfhttps://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/869586/TRIENNIAL_SCR_REPORT_2014_to_2017.pdf

relationship and the family returned to Durham, father was working away (training) at this time. Within three months Diallo died and there was additional evidence of physical abuse and neglect discovered following his death.

Diagram 1 House moves and parenting of Diallo

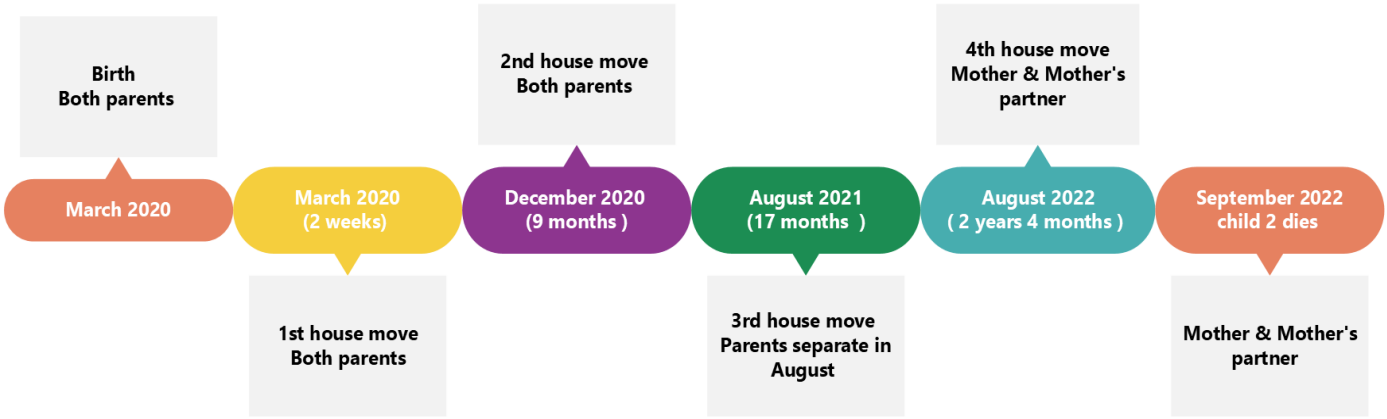


5.7 **Katie** also experienced a number of house moves within the Durham area within private rented accommodation. Her main carer appeared to be father for the first 17 months of her life. Mother commenced a new relationship and the parents separated, and this led to significant distress for father (see below). Mother's partner moved in following the fourth house move. The reasons for the home moves are not fully clear, the condition of some of the accommodation was reported to be poor. Moving house is likely to have placed additional pressures on the family unit with the first move taking place when Katie was just two weeks old. These are vulnerability factors that should inform any work with the family and prompt some enquiry about why and the impact of this. There is information known that the family were experiencing financial pressures.

5.8 Mother was employed as was father for some of the time. It would appear financial pressures were a factor that led to Katie being withdrawn from her first nursery. The consequence of this was that Katie did not attend nursery until she became eligible for a free nursery placement at 30 months The rapid review identified a possible missed opportunity to consider a referral to early help. On the same day that the private nursey advised mother she would need to make some contribution towards paying the nursery /childminder debt mother had a telephone consultation with her GP disclosing low mood and anxiety. Whilst she was provided with a short-term prescription and advice regarding a self-referral to Talking therapies this was not followed up or additional support discussed. This would have been good practice and was a missed opportunity to offer support to the family and understand the family's needs at an early stage through Durham's early help systems. [13]

[13] Early Help in Durham (durham-scp.org.uk)

Diagram 2 House moves and parenting of Katie



5.9 The service that had the most direct knowledge of **Diallo** was the private nursery that he attended three afternoons a week for a short period before he died. The nursery reports appropriate introductions were made, mother had initially sought a place for both children, but they were unable to accommodate the younger child at the time. No concerns were raised, and Diallo was observed to be independent in toileting and eating and was always well-dressed, clean, and tidy. He was described as a happy little boy who had a ready smile, he was just starting to interact with other children and loved cars and messy play. His speech was limited but this did not raise concerns at this early stage of getting to know him. He wore long-sleeved clothes appropriate for the weather and no bruising or marks were evident. He separated with no distress on mother leaving and his mother waited to see him settle. Positive parent-child interaction was observed, father was reported to be on placement, and he was never met. Mother completed the necessary registration forms. There were no reports or requests relating to his culture or religion, he was recorded as Black British and Christian. The nursery was aware that the family had moved from their home area and had no family support, no services were involved other than the health visitor and GP.

5.10 **Diallo** qualified for the universal free early years place for 3- and 4-year-olds for up to 15 hours a week[14]. He attended for around 7 weeks. Mother reported issues with her car explaining it was difficult to get on her own walking with both children, the nursery made efforts to be flexible, but she did not return. Nursery provision is not compulsory, and it was left she would get back in touch when the car was working again. There was no indication of any safeguarding concerns.

5.11 **Katie** attended two private nurseries in the period, the first nursery/childminding place started when she was about 18 months. There were no concerns raised about her presentation, care or behaviour from the nursery who described her as a lovely and engaging little girl enjoying play activities. She showed some upset about separating from her mother but soon settled and mother messaged regularly to see how she was settling. Mother liaised well with the provision, and they accommodated her start times depending on her working hours. She attended around eight full days of nursery it is reasonable to assume from the chronology as indicated earlier that there were financial stresses at this time and Katie did not continue with this nursery provision, there were no safeguarding concerns identified and this was a voluntary service. When

[14] https://www.gov.uk/help-with-childcare-costs/free-childcare-and-education-for-2-to-4-year-olds

Katie was 30 months mother and mother's partner registered Katie at a private nursery near where they were living. As part of the registration process mother indicated there were restrictions around father collecting and she would produce a solicitor's letter. Learning identified in the rapid review highlighted the importance of recording parental and care details accurately, so it was clear that mother's partner was not the birth father. Katie attended two 'settling in' sessions and they were reported to go well, she was observed to "*be a typical 2-year-old with no behaviour or recognisable delay concerns reported from any member of staff* "The health visiting service also received notification that Katie would qualify for a free childcare place because she was eligible for a funded place. When children are in receipt of funded childcare the local authority does then hold a record of this for information purposes only as nursery education is not as stated earlier compulsory. Mother then reported that Katie was unwell so did not attend further sessions before she died. There was nothing to indicate to the nursery that there were any risks to her safety and well-being, and she had been seen well and happy within fourteen days.

5.12 Mother of Katie disclosed domestic abuse from the father of Katie to the police after the death of their child. This related to an incident that occurred around after the couple had separated, it alleged concerns for her and her daughter's life and physical assault. Cross-boundary information relating to mother's partner is discussed later.

5.13 The parents of Katie are understood to have been in a relationship for some six years, Katie was the couple's only child. Records show appropriate ante-natal and postnatal risk assessments (mental health and domestic abuse) were completed and showed no concerns. It is of note that neither parent shared their family histories which showed some significant vulnerabilities as a result of a number of adverse childhood experiences (ACEs)[15]. For mother, her father was sentenced to life imprisonment for attempted murder. She experienced low mood and anxiety as an adolescent and struggled to attend school, she was not brought for support with this. Father had a diagnosis of ADHD[16] and received medication to manage this, he was reported to struggle with his emotions and to develop relationships. His father experienced poor mental health and took his own life when he was a teenager. This was known when he was reported missing by his family to the police immediately following Katie's parents' separation. Father's family (sister) shared worries that he was going to copy his late father's actions and had information that supported this risk. Father was found and shared with police that his relationship with his partner had broken down earlier that day he alleged he had discovered she had cheated on him, and they had separated. His reaction was intense and although made safe he declined to access additional support.

5.14 Whilst his family were supportive this was an opportunity to consider any needs or impact on Katie and follow up with services that could offer help and support the *whole family*, whether or not the family live together as a family unit. Research and guidance from the *Fatherhood Institute*[17] highlight the impact of parenthood on fathers and how mental health can adversely affect parenting and their relationships with children and partners. This includes increased stress where both parents experienced mental health

[15] Adverse Childhood Experiences (ACEs). Are highly stressful and potentially traumatic events or experiences that occur during childhood or adolescence.
[16] Attention deficit hyperactivity disorder (ADHD) A condition that affects people's behaviour. People with ADHD can seem restless, may have trouble concentrating and may act on impulse. Symptoms tend to be noticed at early age and when child circumstances change such as starting school. There may also be additional problems such as anxiety and sleep disorders Attention deficit hyperactivity disorder (ADHD) - NHS (www.nhs.uk)
[17] http://www.fatherhoodinstitute.org/2018/fatherhood-institute-research-summary-fathers-and-postnatal-depression/

difficulties as in this instance. A referral for early help support could have alerted services such as the health visitor and GP that the parents had been experiencing difficulties and father was experiencing acute distress and consider the impact of this upon Katie and offer appropriate intervention and support. This information was ***not known*** until the rapid review but was information that was potentially ***knowable***. This requires services to think about the whole family and understand the impact of mental health stresses on the parenting of vulnerable children. Learning from national reviews shows the prevalence of parental mental health problems and that professionals do not always understand how parental mental health can interact with other stress factors or risks in families' lives.[18]

5.15 Information was known in the wider system in the scope of the review that father had attended Urgent Care on two occasions where alcohol had been a factor, one whilst the couple were in a relationship and the second when separated. No more is known about these instances, but they provide information about the child's family experiences.

[19]

Learning point 1 Professionals should be able to recognise the significance of families that move frequently, particularly across geographical areas. Understanding the impact this can have on accessing services and the increased stresses this can present, particularly for new parents.

Learning point 2 It is important that opportunities to offer support to the whole family where there are children, particularly those vulnerable by their age is not overlooked when parents are experiencing mental distress and anxiety. The importance of the 'whole family' practice is key national learning from rapid reviews and highlights the importance of considering all family members and the 'impact of vulnerabilities within the household". (CSPRP Annual Report 2021) [16]

Learning point 3 Appreciating family relationships, particularly about men in the household and their role, is an important consideration in supporting parents and considering newly formed relationships. All professionals must enquire and be curious about fathers/male care givers and their role in children's lives, irrespective of where they are living. Gender bias is one of the most common types of bias and professionals need opportunities to reflect on these and consider how this may affect thinking, behaviour, and practice.

Cross-boundary working and information sharing

5.16 Sharing information in a timely way is a core principle of Working Together 2018[20] and continues to feature as an issue in learning from rapid reviews and LSCPRs, [21] and where families moved across local

[18] April 2023 Parents with a mental health problem: learning from case reviews | NSPCC Learning

[19] Child Safeguarding Practice Review Panel 2021 - annual report (publishing.service.gov.uk)

[20] Working together to safeguard children - GOV.UK (www.gov.uk)

[21] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/984770/Annual_review_of_LCSPRs_and_rapid_reviews.pdf

authority and health service boundaries this was seen to be more challenging. Whilst the rapid review highlighted possible systemic issues because of the families moving within and outside of the local authority boundary this was not supported by the review findings. This is more nuanced in respect of Diallo where he spent time with his maternal grandmother, and this was not fully known or explored. The geographical size of the local authority is significant for Katie due to the distance from one part of the county to the other which meant services and service delivery were changed when she moved from the north to the east of the county.

5.17 Diallo received routine health visiting services in the first 6-8 months of his life, there is some transferred information about initial post-natal checks including information about sickle cell from Staffordshire. Health visiting records show mum received post-natal support and she reported as a single parent with support from her sister. This is accepted at face value and no enquiries were made before there was a move out of Staffordshire. Once mother became pregnant with her second child the family were in Newcastle and Diallo's health visiting oversight transferred. No contact was established with the family in this period and the family had moved to Durham before a new birth visit could be undertaken however the move was known (diagram 1) Health visiting services reflected that records were not always transferred in a timely way and whilst there was good practice in a direct handover of information about the families move from Newcastle to Durham it is unclear if this delay related to the impact of Covid or the identified shortage of health visitors at that time.

5.18 For both children, the number of health visitors was a feature impacting on information sharing as was the context around Covid 19. The timeline and impact of national lockdowns[22] meant all health services adjusted their working practices to manage risks and whilst they continued to deliver services that were needed it was acknowledged that this was more limited, and many appointments were transferred to phone call appointments. Whilst this meant for some families greater access and engagement, for both these families it meant they were potentially less visible and harder to engage and keep track of, further compounded by the turnover of health visitors and the family's mobility.

5.19 Both children received support under the universal pathway[23] which is outlined below providing the suggested contacts as part of the overall support nationally for 0-5 years. Whilst there was some delay and missed appointments review and contacts were within the recommended time frame.

[22] https://www.instituteforgovernment.org.uk/sites/default/files/timeline-lockdown-web.pdf

[23] Health visiting and school nursing service delivery model - GOV.UK (www.gov.uk)

Diagram 3

5.20 **Diallo** has not been particularly visible to health services and his absence and living arrangements with his grandmother were accepted at face value or not noted. He was not seen by his GP for any issues since his move to the northeast and whilst his family were seen on five occasions face to face by his health visitor, he was only seen directly on two occasions; firstly, during a 3-4 month contact for his younger sibling and secondly in his own right when an Early Years practitioner undertook his 2 ½ year health and wellbeing review. This meant he was for part of his life invisible to services. Whilst Diallo was subsequently seen there was no enquiry or attempts to understand directly about his care and relationships within the wider family. This shows both practice and system learning. It was known that maintaining continuity of staffing, which would be best practice, provided some challenges at this time, and this is supported by findings from the Institute of Health Visiting [24]reports on the legacy of the pandemic and workforce and service demands in health visiting.

5.20 The chronology shows a number of missed and rearranged appointments for both siblings including follow-up for advice regarding identified health issues. It is also notable that mother of Diallo withdrew her consent to immunisation, but no reasons are given. Father did not seem to be aware of this or share his wife's reported worries about his communication and eating and chewing issues relating this to tongue tie[25] (the first reference of this to any professionals) in his 2 ½ -year review. The intermittent engagement missed appointments and immunisation withdrawal was a missed opportunity for follow-up, and evaluation of the information held between the GP and health visiting service and consider possible neglect. It is significant that there were nine health visitors and two early years practitioners involved with the family inevitably complicating the transfer of information and potentially impacting on continuity of care particularly where staff

[24] State-of-Health-Visiting-survey-2020-FINAL-VERSION-18.12.20.pdf (ihv.org.uk)

[25] Tongue-tie (ankyloglossia) is where the strip of skin connecting the baby's tongue to the bottom of their mouth is shorter than usual. If not diagnosed as a newborn it can be treated if any problems in eating occur , it can be resolved by a simple procedure completed by a medical professional.

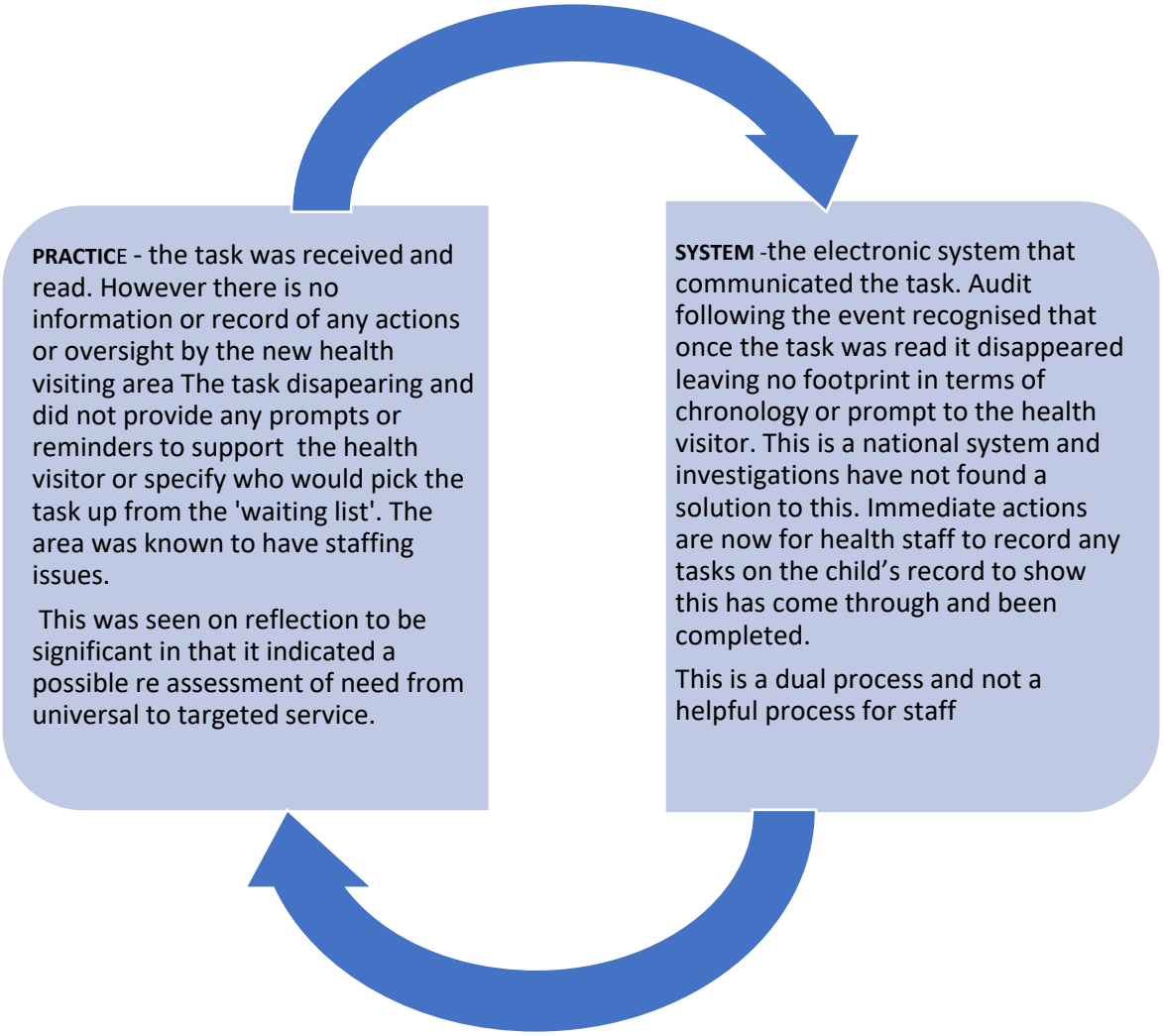
were only in post for a short term (for example agency staff). Information from health visiting services reported that children on the universal pathway were allocated a health visitor from the vacant caseload list (now waiting list) to ensure all children received an appropriate health visiting service against their assessed needs as part of the strategy outlined in section 1.4.

Health visitors are concerned that the needs of vulnerable babies and young children are invisible as they are only able to focus on what feels like the "tip of a very large iceberg" of unmet needs, with almost two-thirds of health visitors reporting an increase in cases of child neglect.

State of Health Visiting in England Dec 2020

5.21 For **Katie** her birth and post-natal care coincided with the start of national lockdown restrictions, situational factors also included the number of house moves (diagram 2) and the high number of staff changes, five health visitors were allocated to the family as well as a duty health visitor who provided (telephone) advice and guidance to mother at what was seen on reflection to be a critical moment for the family (discussed below). There was a mixture of telephone and home visits, whilst there were some missed telephone contacts and three ineffective home visits no concerns were raised and both parents were present for her 9–12-month contact, and appropriate care and interaction were noted.

5.22 Two weeks before Katie died mother contacted the health visiting service and spoke to a duty Health visitor requesting support and raising concerns about her daughter's recent changes of behaviour, mother and child had recently moved, and she stated that the nursery was also raising concerns. (in the strategy meeting the Nursery confirmed they had not expressed any concerns) The information was appropriately passed to Katie's health visitor requesting support and a transfer to the new health visiting team via the child's electronic record. A follow-up home visit to the family was recommended and there was nothing that would suggest immediate action was needed. The new behavioural information shared by mother, her anxiety and her request for support were assessed and a home visit was recommended, procedures state this should be within 2 weeks however within two weeks events overtook. As the family had moved areas the usual process was to transfer the family to a health visitor in the new area, it is noteworthy here that given the geography of the local authority area, the move was some 45 minutes away and possibly tasking the health visitor who knew the family would not have been a realistic option so the referral to a new team was appropriate. There is however both system and practice learning identified here



5.23 The rapid review reflected that the behaviours described by mother could be indicative of a child in distress which whilst being an appropriate hypothesis presents a risk of applying hindsight bias. The issue here is the delay in contacting mother and undertaking a home visit to fully assess the child and mothers needs in a timely way. It is not known if mother shared that her new partner had moved in, a conversation with the nursery to explore this would have been an appropriate action here and may have flagged the discrepancy in mother's self-report and recent changes. However, there was nothing to indicate an urgent response was needed and transfer processes were put into place.

5.24 There was some information held by the police with regards to domestic abuse in both family situations this was known at the time for Diallo's family, consideration of Katie's situation is more complex. For Diallo, there is information on a period of separation and difficulties prior to the reported separation. Diallo's father attended the police station in Stockton-on Tees (where he was working at the time) and shared difficulties in the marital relationship. He went on to disclose an assault by his wife. Father subsequently did not go on to make a complaint and said his wife was a wonderful mother and did not want to pursue this. Police records show that the father had attended for advice only in relation to this and declined to share more information. A DASH[26] risk assessment was completed demonstrating good gender-inclusive practice but given the

[26] The Domestic Abuse Stalking and Honour-Based Violence (DASH) is a multi-agency tool to proactively assess and keep victims and children safe https://www.dashriskchecklist.com/

minimal information, there were questions raised in the learning group about the quality of this information. There is no information to suggest a referral was made to children's services but given the context of the referral i.e., men are less, likely to report an incident than women, a proactive referral to children's services would have been helpful here and included the information about father worries that mother may leave the country with the children. There was certainly enough here to be curious about.

5.25 There is historical information held by Staffordshire Children Care regarding a CAFCASS contact for a safeguarding check[27] instigated by father when Diallo was just 4 months old to seek paternity which indicated there was disagreement about this. The case was closed to CAFCASS following an agreement about this. Subsequently parents and Diallo moved to Newcastle and mother became pregnant with her second child. (see diagram 1)

5.26 In relation to Katie her father stated he had concerns about mother's new partner who was now living with his daughter, these were not specified and as a result were not seen to be significant. He telephoned First Contact and wanted to know if there were any known concerns about a male who was in a relationship with his ex-partner. First Contact appropriately shared that they could not disclose this type of information and signposted him to the Police. Whilst this was appropriate to the request regarding individuals' private personal information best practice could have offered guidance and access to preventive services for a separated father who was concerned enough to call services, and this would have shown good professional curiosity. Recent national Child Safeguarding Practice Reviews[28] highlighted the importance of listening and responding to family concerns and this report was published was widely known.

5.27 Father did follow up with the police the same day for the matter to be progressed through established Disclosure processes by the police (i.e., "Claire Law"[29] the Domestic Violence Disclosure Scheme (DVDS) or "Sarah's Law" [30]the Child Sex Offenders Disclosure Scheme.) The police followed this up and contacted mother by telephone who subsequently reported she was no longer in a relationship with the male in question, therefore the matter was closed. The decision to close the request, based solely on mother's self-report and no follow-up face-to-face visit, showed a limited understanding of the nature of intimate partner violence and abuse and its impact. It also prevented any further opportunity to collate details about mother's new partner and assess any risks through a Claire's Law disclosure. This learning is supported by learning from the independent police investigation which found improvements were needed to ensure a more rigorous assessment of the potential risks to a child following disclosure requests and included improvements to the quality of police information-sharing processes and staff experience within the MASH in line with agreed national guidelines and best practice. Whilst further safeguarding checks should have been progressed there was no finding that this could have caused or contributed to Katie's death.

5.28 Information about mother's partner was shared at the Strategy Meeting following the serious incident that was held by a neighbouring police force however unless it was known where the male was living, the

[27] CAFCASS make checks following an application to see if any information is held about a family of children services, healthcare providers and the police

[28] National review into the murders of Arthur Labinjo-Hughes and Star Hobson - GOV.UK (www.gov.uk)

[29] This enables the police to disclose information to a victim or potential victim of domestic abuse about their partner's or ex-partner's previous abusive or violent offending. Information Sharing (proceduresonline.com)

[30] This enables the police to disclose if someone has a record for child sexual offences

nature of any offences or behaviour, who he was living with and any risks to children it is not information that would be known.

5.29 The chronology shows seven separate episodes of attendance at an Urgent Care Centre[31] for Katie's mother relating to abdominal pain, two falls resulting in a strained ankle and a head injury that involved alcohol. Parents had separated in this period and mother had accessed support for her mental health six weeks earlier. This information was known within the primary care systems and practitioners at the learning event reflected on how they could adopt a more holistic family approach within existing systems and practice at an earlier stage. Since the period of the review, this has been implemented in urgent care however ensuring this information was available to GPs could have enabled them to identify earlier on possible support and intervention and consider access to early help support.

Learning point 4 Ensuring all children in the household are enquired about and seen is important to ensure children are not invisible to services and have their needs fully considered. Keeping an open mind and asking questions rather than simply accepting something at face value is an important skill for practitioners when working with families and demonstrates an essential practice skill by taking a ***professionally curious*** and ***respectfully uncertain*** approach.

Learning point 5 Worries from family members, including separated fathers to First Contact should consider offering guidance and access to relevant support and services such as established father and carer support groups in the locality. Practitioners in First Contact need to reflect on the possibility of unconscious bias towards fathers who may need support in their own right. It is acknowledged that everyone has biases some of which may be conscious of and others we are not. This can be supported and challenged through reflective supervision and personal and organisational learning and development

Learning point 6 Follow-up by the Police for disclosures under Claire's law should not simply rely on telephone self-reports from potential victims who may not be in a position to openly share the nature of their relationship.

Learning point 7 It is important that processes in place are strengthened to review and share patterns of attendance for non-emergency medical care, particularly for adults who have responsibility for children, with other key health professionals involved in their family's care such as the health visitor and GP. This has the potential to enable additional earlier support to be identified and provided to the family.

Professional curiosity and critical thinking

5.30 Professional curiosity for the purpose of this review is about how professionals were able and showed an interest in families' lives and used their skills to engage with families through conversations, observations, and information sharing to try and understand what could be happening for a child and family. Research and reviews repeatedly highlight the significance of information sharing and its relevance in supporting practitioners to see and understand information through a whole family and multi-agency lens. Whilst there

[31] A type of walk-in clinic GP led to diagnose and deal with more common ailments as an alternative to A&E

was information not fully known by the services that had contact with the families some of this information was known and could have led to further enquiry, curiosity and importantly signposting to early help support. This meant that professionals were acting in isolation and working with limited appreciation and enquiry. Practitioners reflected at length on this, and single agencies focus on the quality of their interactions and being more curious and thinking critically about situations and events including

- Enquiring and seeking to understand the number of house moves and its impact on the family
- Exploration and challenge about a child's whereabouts
- Maximising opportunities to engage, support, share information and follow up following mental health episodes and consider the impact on the family.
- Thinking critically about separated parents and the role of fathers and what support could be offered
- Information sharing and curiosity about multiple attendances for treatment and/or care
- Critical reflection and oversight of disclosures of domestic abuse
- Challenging their own assumptions and possible bias regarding gender, ethnicity, and religion and the impact of wider family culture

5.31 DSCP has access to a range of briefing and guidance[32] about Professional Curiosity and what can get in the way, this is positive, but this could be strengthened by providing direct practice learning. All practitioners not just social workers must be familiar with this practice and are supported by robust reflective supervision and oversight. Findings from LCSPR share that this 'authoritative enquiry 'needs to happen across all parts of the safeguarding system, in direct practice with parents, in supervision and in interprofessional challenge. (National Panel 2021)

Race, ethnicity, and culture (Diallo)

5.32 There is limited information in the records regarding the family's ethnicity, culture, and religion until after the incident when the religious views of mother became apparent in relation to medical consent and finding religious artefacts and messages throughout the house. The relevance of these is not known at the time of writing, however, what emerged in the learning event was that professionals were unsure about the culture and religion of the family meaning that it was fully considered. Whilst the children's religion was recorded, and reported by Mother as Church of England, there was confusion about Mother's particular faith and beliefs What subsequently became known was that maternal grandmother held strong religious beliefs and this formed part of Mother's own parenting history and grandmother is highly likely to have continued to have influence in the care of her grandchild when they continued to live together and when she cared for Diallo solely for periods of time. The support networks for the family were simply accepted and not explored.

[32] Resource Library (durham-scp.org.uk)

5.33 Professionals at the learning event reflected on their own lack of knowledge about specific cultures and religions and this appears to have directly impacted their confidence in asking about this and aspects of parenting and beliefs that may be related to this. This is a significant omission from services in understanding the child's experience possibly because of a desire to be culturally sensitive but it has meant that aspect of the family's identity and culture is silent across all services and results in the family's racial, ethnic, and cultural and religious identity not being appropriately considered alongside other experiences. The significance of racial, ethnic, and cultural identity and its impact on the lived experience of children and families is a central practice theme identified by the Child Safeguarding Practice Review Panel [33](2021) that can make a difference when working with children and families.

Learning point 8 It is important that when working with families' practitioners should demonstrate an understanding of the impact that race, culture, and religion can have on parents' behaviour and consider ensure this is discussed and forms part of the family's narrative and experience of services. Practitioners do not always have the confidence, knowledge, and skills to demonstrate sufficient curiosity and any challenge.

Learning point 9 Services dealing with domestic abuse allegations must ensure that staff take full account of gender, race, and other individual and wider family characteristics in considering risk and vulnerability

6 Summary and recommendations

6.1 Learning from this review has identified a number of key themes for the partnership to reflect and action, the cases were atypical as neither family had a history with social care but were open to universal services. Initially learning was thought to be around cross-boundary issues following information that both families had moved several times. Whilst the mobility of the families was an issue and made the family's situations more complicated, it was only Diallo who moved across local authority boundaries, and it was his invisibility to services and a number of changes to his primary carer that were most significant. Similarly, for Katie it was her lack of a stable home base, separation of her parents and potentially safeguarding information not known about a partner that was most significant here, whilst she moved several times, she moved within the same local authority boundary. However, the large geographical distance across the local authority needs to be acknowledged with respect to families who move around the region which necessitated team and staff changes. The number of health visitors both families experienced as a result of team changes and staffing issues is likely to have impacted on the continuity of care and timeliness of information sharing. Nonetheless, both children and families were seen and observed by services and did not present concerns.

6.2 There were however a number of opportunities where additional support and services could have been offered and helped to gain a clearer understanding of the children's lived experiences this is important learning for the partnership, particularly in relation to the adult issues and being more curious and enquiring.

[33] Child Safeguarding Practice Review Panel: annual report 2021 - GOV.UK (www.gov.uk)

There are pressures across the partnership in terms of staffing for health visiting services that are impacting on continuity of care particularly at a universal level and access to help when families may need additional support. These are tragic events, and the partnership has through this review sought to consider what if anything could have been done or known differently, there is learning for the partnership to take away in relation to children and families who are not seen to need additional help. However, there is nothing to say this could have prevented the tragic deaths of these two young children. There were examples of good and effective practice identified across the partnership

6.3 Since completing this review Ofsted's report[34] into the Multi agency's response to children and families who need help (November 2023) highlighted important learning that is relevant here about how "quick access to low-level preventative support can make a big difference to the experience of children and families" and the importance of an approach that is both families focussed, and child centred.

In addition to the learning identified and single agency learning already progressed the following recommendations are made to the Partnership.

1. The Partnership to consider how it can strengthen practitioner skills that enable respectful enquiry and curiosity that facilitate open conversations with families about parenting, relationships, and their own lived experiences. (Learning points 2, 3, 4, 7, 8)
2. The Partnership to ensure services that support /come into contact with adults who are parents follow a 'whole family' approach. There should be clear pathways to early help and preventative services that consider the impact of adult issues on the child. (learning points 2,3,7)
3. The partnership to consider how early opportunities to share information and triage family needs can be most effectively used across early help, health visiting and GPs. This relates to the coordination of early support services at a preventative universal level and aligns with the Partnership's strategic approach to early help.
4. The Partnership to seek assurance from HDFT that its workforce can meet current demand across the partnership. The Partnership to consider and understand the impact of this on children and families with low levels of identified needs and access to preventative support (including learning point 4)
5. HDFT to raise the recording issue of the child electronic system removing a record of Tasks nationally. These should remain on the system to support the child's chronology and performance management.
6. First contact to ensure it demonstrates professional curiosity when separated fathers share worries about their children and provide information, guidance, and support as needed. (learning point 5)
7. The Police to assure the Partnership that its decision-making and outcomes within the MASH relating to Claire's Law and Sarah's Law disclosures where children are identified comply with national police standards and legislation including the 1989 Children Act and Home Office statutory guidance. (including learning point 6)

[34] The multi-agency response to children and families who need help - GOV.UK (www.gov.uk)

8. The Partnership to ensure practitioners and systems can demonstrate in records, assessments, and interventions that race, ethnicity, and culture directly inform the family's narrative. (learning point 8, 9)
9. The learning from this CSPR is disseminated across the Partnership.