Child Safeguarding Practice Review (CSPR)

Child Charlie

Agreed by: Somerset Safeguarding Children Partnership in May 2021

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1. Executive summary. About this review

1.1. This review is being completed following the unexpected death of a 16-week-old child who will be referred to as Charlie. Charlie died in early 2020 whilst in the care of father and the cause of death is the subject of ongoing criminal investigation.

1.2. The statutory safeguarding partners decided to conduct a Child Safeguarding Practice Review (CSPR) to identify what can be learnt from how the safeguarding system responded to the issues in this case. The review has been facilitated by an individual who is independent of agencies in Somerset. The CSPR covers the period from when Charlie was born up to the date of death.

1.3. Charlie lived with mother who had separated from Charlie's father about a month after Charlie's birth. It is understood that mother ended the relationship due to father's 'drinking and behaviour'. Mother did not have her own home and had made an application to the housing authority. A short time later, the relevant Somerset district council accepted the case and agreed to provide support under the relief duty of Housing Act 1996. In the interim, Charlie and mother stayed with family members.

1.4. Five incidents of domestic abuse were reported to the Police during Charlie's life with the first being reported on the day mother ended her relationship with father. Information from the family indicates that an incident of domestic abuse also took place the day before Charlie died. This incident was not reported to the Police. The incidents were reported by mother, a family member, two members of the public, and father. Mother was identified as the victim in four of the five reported incidents and in the other, both parents made allegations against each other.

1.5. Statutory partners determined that the CSPR should focus on the inter-agency response to children living with domestic abuse. The Police were the only agency that were aware of all five incidents of domestic abuse and during the period covered by the review there were pilot arrangements in place for the Police to share information with partner agencies about children they identified as living in households with domestic abuse.

1.6. Whilst this review will focus on the issue of domestic abuse, it is important to state that the rapid review identified the presence of known risk factors in relation to safe sleeping, e.g. co-sleeping with a heavily intoxicated adult, cold

surroundings and probable smoking and drug use. The second national CSPR[1] published by the National Panel in July 2020 provides learning in relation to a prevent and protect practice model for reducing the risk of sudden unexpected death in infancy that Pan Dorset and Somerset statutory child death review partners, in conjunction with Somerset Safeguarding Children Partnership (SSCP), can use to inform future activity to prevent sudden unexpected death in infancy.

1.7. The CSPR has built on the learning identified in the rapid review and drawn on a range of information including the views of a range of frontline practitioners. Family members were invited to contribute although elected not to do so. The review has adopted a systems approach by going beyond identifying what happened to exploring the context in which professionals and organisations operated. This approach helps identify the factors in the safeguarding system that support good practice and those which create unsafe conditions in which poor safeguarding practice is more likely to occur. These system insights are in turn used to inform the actions that can be taken to prevent or reduce the risk of recurrence of similar incidents.

1.8. Agencies have 'self-identified' a small number of learning themes to take forward on a single agency basis. In addition, there is strong support amongst agencies who have contributed to this review for a partnership agreement and approach to share information and analyse the needs of children living with domestic abuse. To support this goal, there are three key learning themes arising from this CSPR which are summarised below:

- Leadership and governance. Future safeguarding practice will be strengthened by reviewing the governance of multi-agency safeguarding arrangements for responding to the needs of children living with domestic abuse, including developing a practice toolkit and information sharing arrangements.

- Practice learning. Future safeguarding practice will be strengthened by a focus on safe outcomes for children living with domestic abuse as opposed to an incident focused response.

- Culture of partnership working and shared accountability. Future safeguarding practice will be strengthened by developing the culture of

[1] https://www.gov.uk/government/publications/safeguarding-children-at-risk-from-sudden-unexpected-infant-death

partnership working and therefore individual and collective accountability for safeguarding children.

1.9. Agencies began to act on learning following the Rapid Review held after Charlie's death; an overview of the improvement actions taken to date is provided. The review concludes with an action timeline that has been devised by members of the Learning and Improvement subgroup. This timeline will be used to take forward the partnership learning. Another CSPR has been completed alongside this CSPR and has been authored by the same reviewer. There is a synergy between these two CSPRs in relation to learning about the culture of partnership working and shared accountability and understanding of the various components of the health system; a single set of actions has been agreed to take forward this learning.

1.10. The progress and impact made as a result of the implementation of the learning from this CSPR will, in accordance with statutory guidance, be publicly reported in a future SSCP twelve-monthly report.

2. Story prior to the incident and around the incident

2.1. Charlie was born in hospital in the presence of father and maternal grandmother. Hospital staff noted that father appeared 'spaced out' or possibly under the influence of alcohol in the labour ward. Ward staff identified similar concerns in respect of father post Charlie's birth; no such concerns had been identified during the ante-natal period. There is no documented evidence that this matter was discussed with mother. Furthermore, it was not flagged on mother's electronic patient record and nor was a safeguarding alert sent to the safeguarding midwives.

2.2. No information was shared prior to Charlie's birth with partner agencies to indicate that Charlie's mother was at risk of domestic abuse. Primary care held information about father's history of drug addiction, alcohol dependency and minor injuries due to fighting. Father's GP did not know he had become a parent. Adult Mental Health Services' records indicate father had been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD).

2.3. Mother ended the relationship with father when Charlie was approximately one month old; it is understood that this was due to father's 'drinking and behaviour'. After leaving father's home, mother and Charlie stayed with family members and

sought support and assistance from the housing authority. Prior to mother ending the relationship with father, no concerns had been identified by midwives who conducted home visits nor the allocated health visitor who completed the new birth visit.

2.4. There were five incidents of domestic abuse reported to Police during Charlie's life; the first of these was on the day mother ended the relationship. During the period covered by this CSPR, a Domestic Abuse Triage (DAT) pilot was in operation which provided a forum for Police to share information with partner agencies in respect of children they identified as living with/exposed to domestic abuse. The table overleaf provides an overview of the incidents; including assessments completed.

Incident	Referrer	DASH completed/ outcome	Police Vulnerability Tool* completed/ outcome *Known as BRAG	Referred to Lighthouse Safeguarding Unit (LSU)	Number of working days between domestic abuse incident and DAT discussion	Referred to DAT	Recorded DAT outcome
1 (Day relation-ship ends)	Neighbour	Yes – Medium risk	No	DASH shared with LSU	Not applicable	No (+PHN not made aware)	Not applicable
2 (next day)	Mother	Yes – Medium risk	No	Yes	2	Yes	"Referred to health"
3 (12 days after incident 2)	Neighbour	Yes – Officer perceived DASH completed – standard risk	Yes – green (Indicates there are some welfare concerns which cannot be met by officers and that consideration should be given to onward referrals)	Yes	Not applicable	No (DAT suspended at request of 1 partner due to staffing/ capacity issues)	Not applicable

4 (17 days after incident 3)	Family Member	No – not identified as domestic abuse incident as not involved individuals aged 16+ who were family members or were/had been in an intimate relationship	Yes – Amber, (Indicates no immediate risk but that may be a risk of significant harm if the activity /concern continues)	Yes	1 i.e. next day	Yes	"Referred to health"
5 (8 days after incident 4 and 6 weeks prior to Charlie's death)	Father	Standard	Yes – Green (Indicates some welfare concerns which cannot be met by officers and that consideration should be given to onwards referrals)	Yes	1 i.e. next day	Yes	Refer to Children's Social Care

2.5. The DAT pilot commenced in September 2019 and was a daily meeting involving Police, Children's Social Care, Somerset Integrated Domestic Abuse Service (SIDAS), Somerset Partnership NHS Trust and local authority Education Safeguarding Service. Its purpose was to triage incidents of domestic abuse involving children that the Police had received in the preceding 24 hours. The aim of DAT was to perform an assessment as to which agencies required a Police report in respect of the domestic abuse incident; the outcome of DAT was recorded by Police.

2.6. Like CSPR Alex, this review has found the term 'health' was used without specifying which health provider or part of the health system was being referenced. An action was agreed as part of CSPR Alex to promote a shared and consistent understanding of the different components of the health system. This action will also address the parallel learning arising from this review and for completeness, it is included at Section 7 of this report. The DAT outcome 'refer to health' equated to a copy of the Police domestic abuse incident report being sent to Public Health Nursing (PHN). The Police already had an arrangement to share information about domestic abuse incidents involving children under five with PHN and as a result, Somerset Partnership NHS Trust withdrew from the pilot as they determined there was no added value to them being in attendance given that PHN were already notified of domestic abuse incidents by the Police. Information regarding domestic abuse incidents considered by DAT were not shared with any other part of the health system, including primary care.

2.7. PHN were notified by Police about four of the five domestic abuse incidents. There was no follow up to the first incident of domestic abuse they were made aware of until a few weeks later, by which time PHN had been made aware of a second incident of domestic abuse. Both incidents were discussed jointly with mother and father and both parties indicated they intended to proceed amicably for Charlie's sake. The Health Visitor service offer was subsequently re-assessed from universal to universal plus enhanced service which was an appropriate response.

2.8. Seven days after visiting Charlie and his parents, the PHN was made aware of a third incident of domestic abuse that had occurred two days earlier, i.e. five days following the visit to Charlie and his parents. The health visitor made contact by text with mother seven days after PHN received this notification however, by this date, a further incident of domestic abuse had taken place the day prior to the health visitor contacting mother. The health visitor was not aware of the most

recent incident when she contacted mother and mother did not share any information about the most recent incident. When the health visitor discussed the third incident that they had been made aware of with mother, mother texted that her intention was not to allow Charlie to have contact with father. The health visitor understood that mother was not allowing any contact to take place whilst father continued to drink; the reality was that Charlie had been exposed to a further incident of domestic abuse the previous day.

2.9. The fifth incident of domestic abuse that was reported to Police resulted in a referral to Children's Social Care (CSC) following discussion at DAT. Following oversight by a Team Manager in First Response service, the case was allocated to a worker from the Emergency Duty Team (EDT) rather than a worker from the First Response Team. There is no evidence in CSC records that this action was taken due to failed attempts to contact mother during the working day and so the most likely explanation for the case being allocated to an EDT worker is volume of work in the First Response team.

2.10. The EDT worker contacted mother who advised that she had not allowed contact between Charlie and father since the fifth domestic abuse incident and that she would not do so until father sought help in relation to his alcohol misuse. No contact was made by CSC with father, extended family members or other agencies, e.g. primary care. A decision was made by the EDT worker to close the case; this decision was made independent of management oversight as EDT practitioners are advanced practitioners and, at that time, signed off their own work. The basis for the decision to close the case was that mother had and continued to act protectively and the health visitor was continuing to support Charlie and mother. The EDT worker had access to PHN records and so was able to confirm their ongoing involvement. However, the lack of contact with family members and other professionals resulted in the case being closed without a clear plan being in place to safeguard Charlie.

2.11. Following the fifth incident of domestic abuse, in addition to being contacted by CSC, mother was contacted by a victim and witness care officer from the Police, and the health visitor also contacted mother once made aware of this incident of domestic abuse. This incident took place at father's home following mother and Charlie joining father for dinner so that father could have contact with Charlie. The health visitor advised mother that Charlie should have no contact with father until a safety plan was implemented. One of the factors that

influenced the health visitor's assessment of Charlie's safety following this further incident of domestic abuse was the outcome of the recent referral to CSC.

2.12. Two days prior to Charlie's death, the health visitor conducted a home visit to mother and Charlie. Mother informed the health visitor that Charlie was having contact with father supported by paternal grandmother.

2.13. Since Charlie's death, agencies learnt of an incident of domestic abuse the evening prior to Charlie's death; this incident took place at father's home. In addition, information shared by the family after Charlie's death indicates that Charlie stayed overnight with father two nights per week and every other weekend.

2.14. In terms of primary care, mother and Charlie were registered with the same GP practice. Mother attended the surgery for her six-week post-natal check; information about domestic abuse. Father was registered with a different practice and had visited his GP after the second incident of domestic abuse to discuss his alcohol use. He was advised to self-refer to local substance misuse services. Neither GP practice had any knowledge about the five incidents of domestic abuse reported to the Police and father's GP did not know he had become a parent.

3. Application of relevant research, policy and other reviews

3.1. A Research in Practice Review[2] reveals: -

- Almost a quarter of young adults in the UK have witnessed domestic abuse during their childhood, and almost 1 in 20 (4.5%) children and young people in the UK have experienced severe forms of domestic abuse.
- Children and mothers who experience domestic violence are likely to do so on a repeated basis.

[2] Children Experiencing Domestic Violence: A Research Review (Stanley 2011) details the research and evidence around prevalence, effects on children's development, the interaction with parenting and children's health and well-being, and service responses. www.rip.org.uk/publications

- Domestic violence is also a key indicator for child abuse and neglect, with children exposed to domestic abuse being three to four times more likely to experience physical violence and neglect.

- Parental separation does not guarantee an end to violence. For one in two families who separate, the domestic abuse continues beyond separation, and separated women are at particularly high risk. For many families, contact provides a context for domestic abuse to continue.

3.2. The Joint Targeted Area Inspection (JTAI)[3] that explored the multi-agency response to children living with domestic abuse identified that agencies focused on the adult(s) and children at immediate, visible risk which resulted in an insufficient focus on the perpetrators of abuse. The inspectorates found that an incident-led approach and a lack of focus on perpetrators resulted in a short-term view of risks. Furthermore, inspectors observed that agencies placed an inappropriate attribution of responsibility on the mother to protect her children. The end of an abusive relationship is considered by professionals to reduce the risk to children, when in fact research tells us that separation can escalate risk[4]. When agencies fail to address the perpetrator's behaviour, the perpetrator can leave their home without any follow up action and repeat the behaviours from afar or in a new relationship. The following quote from the second JTAI Inspection reinforces why agencies need to focus on perpetrators:

> *"Taken across many cases, a focus mainly on the victim fails to address a range of important factors at play. These include the experience of the child, the root causes of violent behaviour displayed by the perpetrator, and the impact on other family members. Furthermore, without a focus on the perpetrator's mindset and behaviour, there is a high risk of recurrence once the immediate crisis has passed. While we need to support victims to help them protect themselves and their children, we must not lose focus on the perpetrator, their behaviour, and their accountability for their actions."*

[3] The multi-agency response to children living with domestic abuse. Prevent, Protect and Repair. September 2017, No. 170036 .
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/935983/JTAI_domestic_abuse_18_Sept_2017.pdf

[4] Harrison, C., 2008. Implacably hostile or appropriately protective? Women managing child contact in the context of domestic violence

3.3. Applying this to Charlie and both parents, the focus on mother to take action to protect Charlie from father prevented an exploration of Charlie's lived experiences including contact arrangements, the impact of father's substance misuse and ADHD on his behaviour as well as the role extended family members played or could play in managing the ongoing risk.

3.4. Research in Practice[5] call for a cultural shift in practice whereby the focus of professional intervention becomes safe outcomes as opposed to an immediate response to the presenting incident. Research[1] has identified the following as components of an approach that is responsive to the needs of children experiencing domestic abuse:

- Engages with families on the basis of a shared understanding of the harm experienced by children living with domestic abuse, rather than utilising blame or threats;
- Seeks to involve all family members, including perpetrators, while recognising that it may not always be safe or appropriate to see all family members together;
- Distinguishes appropriate pathways for families experiencing domestic violence using risk assessment that incorporates evidence from the full range of services;
- Recognises the need for long-term engagement with families who have complex needs and embedded histories of domestic abuse, but neither assumes nor is predicated upon separation.

3.5. Somerset County Council and partners are implementing the Family Safeguarding Model[6] pioneered by Hertfordshire Council. The model creates family safeguarding teams that comprise both children's social workers and specialist adult practitioners. The latter bring expertise focused on domestic abuse, mental ill-health and substance misuse; domestic abuse specialists are available to work with perpetrators as well as victims. Another key feature of the model is motivational interviewing, a strength-based technique via which practitioners work alongside people to support them to make changes to their

[5] https://www.researchinpractice.org.uk/children/content-pages/slides/domestic-abuse-and-violence-developing-more-effective-responses-in-children-and-young-people-s-social-care/
[6] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/932367/Hertfordshire_Family_Safeguarding.pdf

behaviour. It is characterised as a 'do with' rather than 'do to' approach. This model creates an opportunity to work differently with parents/carers who require statutory social work intervention; there will of course be many children who will experience domestic abuse whose needs do not require statutory social work intervention where early intervention services can reduce the need for future statutory intervention and a 'do with' approach will also be required for these children and their families.

3.6. Health providers[7], including GPs, have a key role to play in identifying victims of domestic abuse, with research[8] indicating that GPs are considered by victims to be the professional they most trust to disclose to, comparable only to friends and family. Police call out to a domestic abuse incident is often the first moment when family violence is exposed, and these incidents are the principal means by which Children's Social Care are informed about children's exposure to domestic abuse. They present an opportunity for public services to identify need and instigate the process of delivering interventions to protect victims and children and support perpetrators to change their behaviours.

3.7. Stanley et al[9] identified that developing co-ordinated responses across criminal justice and child welfare systems requires considerable strategic planning; this includes managing the potential high volume of notifications that Children's Social Care can receive when there is no filtering of the notifications. They analysed Police notifications of domestic abuse incidents to Children's Social Care in two local authorities and analysed the subsequent filtering and service response. Notification triggered a new social work intervention in only 5% of cases and social workers found that notifications conveyed little information on children's experiences of domestic abuse; this reflecting Police officers' limited levels of engagement with children at the scene of the incident[10]. The study identified four key approaches to collaboration in the management of notifications and found inter-agency panels, team or co-location arrangements

[7] Department of Health (2017) Responding to Domestic Abuse: A Resource for Health Professionals. Bit.ly/DHDomesticAbuse

[8] Richardson et al. (2002) Identifying domestic violence: cross sectional study in primary care, British Medical Journal, 324

[9] Children's Experiences of Domestic Violence: Developing an Integrated Response From Police and Child Protection Services Nicky Stanley, Pam Miller, Helen Richardson Foster, and Gill Thomson Journal of Interpersonal Violence 08 2011 ; vol. 26, 12 : pp. 2372-2391. https://doi.org/10.1177/0886260510383030 Posted online on October 1, 2010

[10] Stanley, N., Miller, P., Richardson Foster, H. and Thomson, G. (2010). Children and Families Experiencing Domestic Violence: Police and Children's Social Services Responses, London, NSPCC, available online at www.nspcc.org.uk/Inform/ research/Findings/children_experiencing_domestic_violence_wda68549.html

that maximise opportunities for agencies to share information and that seek to develop workable procedures for sharing information have much to offer including developing the means of ensuring that families who do not require a statutory social work service are offered other forms of support in relation to domestic abuse. Given 'the severity of a particular incident is distinct from and may not be related to the impact of domestic violence on children in the family' and the information required to inform a calibrated response to the needs of families experiencing domestic abuse has to be obtained from a range of sources, the research concludes that there is a strong argument for developing collaborative structure that promotes effective information sharing to identify what support should be provided to the child and family.

3.8. Finally, research by Herbert et al[11] aimed to identify the factors that influence the quality of inter-agency collaborations. These are broken down into: -

- Enabling factors
- Process factors
- Individual factors

3.9. Trust and respect and communication and information sharing are indicative of good quality collaboration rather than factors supporting collaboration; they should be considered as describing the change to values and behaviour that are prompted by the other factors. Figure 1 sets out the research findings.

[11] James Herbert , Nicholas Ghan , Mary Salveron & Wendy Walsh (2020): Possible Factors Supporting Cross-Agency Collaboration in Child Abuse Cases: A Scoping Review, Journal of Child Sexual Abuse, DOI: 10.1080/10538712.2020.1856994 To link to this article: https://doi.org/10.1080/10538712.2020.1856994

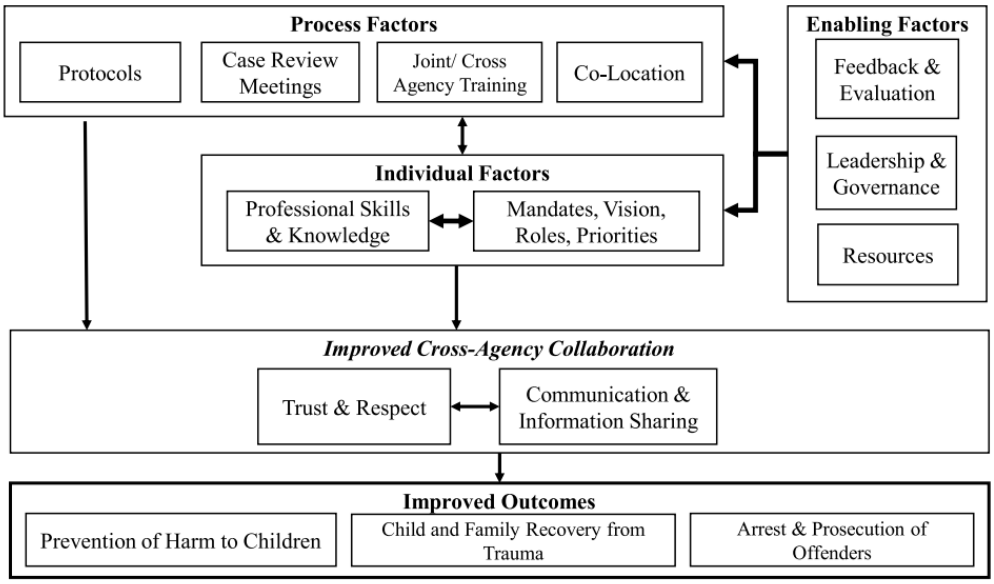

Figure 1. Results of the systematic search of the literature on factors that influence the quality of interagency collaborations.

3.10. Whilst future research is required to better understand the relative importance of the factors, the research points to these factors as potentially all contributing to the quality of collaboration, which in turn is assumed to affect the quality of responses experienced by children and families. The findings therefore provide useful insights for SSCP to both inform and evaluate multi-agency safeguarding approaches involving diverse professional groups.

4. Single agency learning and conclusions.

4.1. The organisations that contributed to this CSPR are set out below at Table 1 alongside a summary of the key learning that they or the reviewer identified for their organisation based on their involvement in this case. In addition, a small number of partnership learning themes have been identified; these are set out at Section 5. Some partner agencies also identified elements of the partnership learning themes as single agency learning for their organisations; that learning is detailed in Table 1 (below).

Table 1

Agency	Key learning	What needs to happen	Evidence the organisation will use to test that learning has been embedded
Avon and Somerset Police	• Increase awareness and knowledge about how domestic abuse impacts on babies	Complete a research review into the impact of domestic abuse/ trauma on babies. Develop a plan to use the research findings to inform a range of internal activity to support the Force to identify and respond to the needs of babies living with domestic abuse.	Audit and assurance work on investigations and risk assessments to ensure the welfare of babies is considered and their needs are appropriately identified and met.
Somerset Children's Social Care	• Understand and explore family relationship/ dynamics; including engaging with fathers/absent parents/domestic abuse perpetrators. • Gather and use information about the nature and history/pattern of domestic abuse incidents to inform assessment and decision making. • Direct conversations with practitioners in other agencies, including GPs, to gather information and agree a clear	Review current continuous professional development offer for front door services, and the wider service, to strengthen understanding of the need to engage with absent fathers and perpetrators of violence and triangulate this information. Continue to work with the police and the wider partnership to support a shared understanding of the need to share history and contextual information.	Practice evaluation programme Dip review of intervention with non-resident parents and perpetrators of violence in First Response– January 2021 Joint audit of police referrals and outcomes with the LSU. Quarterly multi-agency audits of referrals into the front door and decision making led by a First Response Team Manager.

	plan about who is responsible for which elements of support; this includes a clear 'step down' plan when CSC are recommending another agency provides support to a child/family.	Routine multi-agency discussion at the front door to agree and confirm the plan for the child and record this clearly.	
Somerset Public Health Nursing	• PHNs to: (i) Update the Family Health Needs Assessment (FHNA) at every core contact and when new needs/ risks are identified by PHN or shared by another agency. (ii) Use the risk and protective factors tool to analyse the child/family's needs/awareness. • Further embed the Effective Support for Children and Families Framework to support PHNs to evaluate a child's needs and the intervention to be provided. • PHNs to access safeguarding advice/supervision in relation to domestic abuse incidents. • All practitioners to	PHN service working party established to undertake review of FHNA and the linked risk and protective tool. Updating and amending as required to reflect the Effective Support document common language in relation to needs and interventions. Relaunch of updated FHNA via PHN learning sets including standardised guidelines for when the assessment should take place and including timebound interventions and monitoring in line within the continuum of need. The Effective Support document common language to be incorporated into the FHNA as per above action.	Minutes of working party and changes made will be available. Updated FHNA tool will be available and accessed via electronic records. PHN annual record keeping audit will include the audit of use of the FHNA and when undertaken as well as the application of Effective Support document.

	be aware of the process for diary management and allocation of workload in practitioner absence.	All PHN polices/ guidelines to contain link in assessment process to Effective Support tool. Effective Support document referenced in every child protection conference template by HV practitioners. Effective support document referenced in every supervision session. Effective support document referenced, and image shared including links in every safeguarding training module delivered by safeguarding service. PHN managers when notified of staff absence allocate diary management to duty team. PHN managers to affirm practitioners understanding of diary management process with every individual staff member in supervision session.	All policy/guideline documents with assessment process can be viewed to confirm reference to the Effective Support framework as assessment tool. Child protection conference report audit Confirmed in supervision of supervisors. All training modules are available for view and effective support referenced and imaged. Supervision records
Somerset Clinical Commissioning Group	• Primary Care teams and practitioners to enquire about family and social circumstances particularly for	Feedback has already been given to the father's GP and discussed with the wider team as part of their safeguarding meetings.	This should be evident in improved communication with midwives during the pre-birth period (in line with the pre-birth Standard Operating

	parents with drug, alcohol, or mental health issues so they can consider how their actions and behaviours can affect others, e.g. children.	The CCG will also continue to promote this "professionally curious" approach in all its training, supervision, and newsletters.	Procedure) and also safeguarding discussions with HVs during practice safeguarding meetings.

4.2. The learning that will be taken forward within individual agencies will support them to deliver their statutory responsibility to safeguard children by strengthening capacity to:

- Recognise and consider the impact of domestic abuse on babies/children.
- Identify the needs of a child/family.
- Develop a clear plan of service provision/intervention in accordance with the Effective Support for Children and Families framework.
- Reflect on the needs of a child/family.

5. Partnership Learning and conclusions

5.1. The analysis of multi-agency safeguarding practice in this case identifies three learning themes. These learning themes have wider applicability and can therefore be used to improve future multi-agency safeguarding. They are set out at Table 2 below.

Table 2

Learning Theme	Why did the review identify this learning theme?
<u>Leadership and governance</u> The analysis of this case indicates that there is a need to review the governance of multi-agency safeguarding arrangements for responding to the needs of children living with domestic abuse, including practice guidance and processes.	Why did the review identify this learning theme? 1. A DAT pilot commenced in September 2019 involving a number of partners, however, there was no formal governance arrangement for the pilot, including accountability for evaluating the contribution made by partners or the effectiveness of the process. 2. One health provider was involved in the pilot process at the outset, although subsequently withdrew as there was no tangible benefits from the pilot for that partner agency or indeed the health system. This decision was made because there was already an agreed process for the Police to share domestic abuse notifications with PHN. The DAT pilot did not provide a means for information to be shared by/with other health providers, e.g. GPs or adult mental health services. Following Charlie's death, CSC withdrew from the pilot, this was due to concerns about incidents being considered in isolation as well as the volume/suitability of incidents being discussed. There is currently no agreed process for partner agencies to work collaboratively in relation to sharing information and evaluating the needs of children living with domestic abuse; there is strong support that this should be re-visited as a result of the learning from this review.

	3. The DAT operating protocol had not been agreed through a formal governance process and the pilot operated by considering each domestic abuse incident in isolation. In addition, the expectations in relation to information sharing by DAT partners to the daily meeting had not been clearly defined, this reduced the opportunity for decision making to be informed by partners already knew about the child/family. In this case, two domestic abuse incidents were not considered by DAT, one because the incident was not referred and the other because the DAT did not operate over the Christmas holiday period. 4. There was a lack of clarity about roles/expectations of those partner agencies who received the notifications following the DAT taking place. Schools raised issues of consent and whether they could legitimately respond to notifications and practitioners in PHN understood that GPs and Children's Social Care as well as the Police knew about all the incidents that occurred during the DAT pilot. Feedback from practitioners indicates that since the pilot ceased, PHNs are unaware which incidents have been reported to CSC and social workers have informed the review that they learn of domestic abuse incidents for children under five when they contact PHN when completing a child and family assessment. 5. A review of the Effective Support for Children and Families framework, South West region safeguarding procedures and advice on Somerset Integrated Domestic Abuse Services website indicates there is need for SSCP to provide consistent guidance for practitioners regarding how they should respond to children living with domestic abuse. To illustrate, one set of guidance indicates a referral should be made to CSC for every child under 13 living with domestic abuse however, this is not reflected in the Effective Support Framework. That framework recommends that practitioners complete a DASH assessment (adult focused tool) whilst the other two documents recommend

	completion of a child focused assessment tool.
<u>Practice learning</u> The analysis of this case, provides learning that can be used to further develop how services assess and respond to the needs of child and families living with domestic abuse.	1. The response of all partner agencies who were aware of domestic abuse in this case was 'incident' led. Whilst this practice is not unique to Somerset, the case illustrates the limitations of this approach as the true nature and context of domestic abuse, including aggravating factors, is not understood. Domestically abusive behaviour should be defined, and the pattern of perpetrator behaviour understood, in order to inform need/risk assessment and intervention. 2. In addition to being incident-led, there was little or no focus on father, and instead the responsibility to protect Charlie was placed on mother when the person who needed to make changes in order to protect Charlie was father. Assessment of need and support in cases of domestic abuse should be family focused; services will of course need to be cognisant that that there will be cases where it is not safe or appropriate to see family members together. 3. The review has identified the need for clear family focused plans that promote safe outcomes for children living with domestic abuse. The term 'safety plan' is/was used however, the specifics of what the plan was to promote the Charlie's safety were not clear, e.g. no contact between Charlie and father was identified by some professionals as the way to secure Charlie's safety. It was unclear if this meant no contact at all or no contact if father was under the influence of alcohol; it is also not clear how unpredictable father's alcohol use was and how this needed to inform the 'safety plan'. One agency understood the safety plan to be no contact at all, however, when alerted to ongoing contact, they did not explore the potential risk Charlie was exposed to via the ongoing contact. The review has identified the importance of practitioners explicitly exploring overnight contact arrangements for children under two years of

	age. This would allow safe sleeping arrangements to be considered with both parents and is considered an important preventative action given the second National CSPR found that the risk of unsafe sleeping practices increase when a child sleeps outside of their routine sleeping arrangements. Due to a lack of family participation, it is not known whether mother felt coerced into facilitating contact. Victims of coercive control will require support to be able to take action to manage risk. This, of course, should complement rather than substitute actions taken by the perpetrator to reduce risk. 4. Individual agencies have identified two learning points in relation to identifying and managing the risk of harm from domestic abuse and given their significance to future safeguarding and relevance to the wider workforce, they are repeated below: (i) Adults do not live in isolation – practitioners should enquire about family and social circumstances particularly for parents with drug, alcohol or mental health issues; this is so they can consider how an individual's actions and behaviours can affect others. (ii) Cases stepped down by CSC require a clear 'step down' plan so there is clarity about how needs will be met.
<u>Culture of partnership working and shared accountability.</u> The analysis of this case reinforces that shared accountability for safeguarding needs to operate at an individual, organisational and system level.	1. The commitment of agencies to safeguard and support children living with domestic abuse has been clear during the review process; despite this commitment, the CSPR has found that there was not a shared understanding about the purpose of the DAT amongst two of the three statutory partners. One of the main drivers for introducing the pilot was to manage the volume of activity in relation to domestic abuse within the Police and, secondly, to increase the timeliness of notifications being made by the Police to Children's Social Care. Both are important issues; however, it appears they shaped how DAT functioned and resulted in a focus on managing demand as opposed to optimising the contribution of partner agencies to triaging domestic abuse incidents.

	2. As there was not a shared clarity of purpose, partner agencies withdrew from DAT; the lack of formal governance arrangements allowed this to happen without discussion at a senior strategic level across the partnership. Frontline practitioners who contributed to this review identified that inter-agency working would be enhanced if there was a process to share/evaluate information in respect of domestic abuse incidents; supported by guidance regarding action to be taken. 3. There was some evidence to indicate that practitioners were influenced by the outcome of assessments or decisions made by other agencies or forums or the involvement of other agencies and this impacted on the assessment/actions they took. Some practitioners have fed back that they are not aware of referral process to Safer Families [12] and there may also be an opportunity to increase awareness of the range of support services, e.g. SIDAS Helpline for practitioners. Individual practitioners will also need to embrace their professional responsibility to provide intervention to children and families where domestic abuse is a feature of their lives. The outcome of the review of practice guidance discussed on page 17 will support them to do so and access to safeguarding supervision will further equip them to do so.

[12] Safe Families is a charity that works with local authorities around the UK to offer support and respite to children, families and care leavers. They do this by making use of a network of trained volunteers to support the needs of some of our more vulnerable children and their families. You can find out more on their website at www.safefamilies.uk .

6. Learning already implemented

6.1. The CSPR has identified a range of activity that CSC, PHN, Police and the CCG have initiated in response to the incident that led to this CSPR including:

- Pilot project for one-month duration whereby Police shared information about high risk and medium risk domestic abuse cases with GPs; a task and finish group has been established to explore how this could become routine practice.
- Monthly safeguarding supervision sessions have commenced and are facilitated by the Named GP; GPs can bring safeguarding cases, including domestic abuse, for reflection and discussion.
- Continuing Professional Development session on working with the whole family in cases of domestic abuse held for First Response Team practitioners.
- Managers in the First Response Team routinely pass back cases to social workers if the non-resident parent or perpetrator has not been contacted, unless to do so would increase risk to child/other family members.
- CSC decision making in respect of referrals to First Response Team is audited by colleagues from Somerset NHS Foundation Trust, Education, Children's Social Care and Family Intervention Service.
- EDT social workers now reassign contact records to Team Managers to authorise when they are closing a contact with no further action, they no longer authorise closure themselves.
- To provide an additional element of oversight, Team Managers within First Response will reassign the authorising of a contact to another Team Manger if they have signed it off in the previous three-month period.
- PHN have revised their domestic abuse policy to specify and standardise the actions to be taken in response to domestic abuse notifications. Workshops have commenced to support frontline staff understand the changes/organisational requirements.

- PHN have introduced a Level 3 Safeguarding Children Domestic Abuse training module and a domestic abuse routine enquiry and ACPO-DASH assessment workshop has been delivered to practitioners.
- PHN Safeguarding service have begun to use safeguarding supervision to support practitioners to reflect on their response to domestic abuse notifications, including low risk cases.
- PHN have established a working party to review the FHNA and risk and protective tool guidelines; this will include exploring the barriers to practitioners using these tools.
- PHN have updated record keeping guidelines to specify that text messages should not be used for the purpose of assessment or clinical contact.
- A regional joint working group has been established between Police and local authorities to develop a consistent and effective approach to police referrals being made to the five Children's Social Care front door services across the Avon and Somerset Police Force footprint.

6.2. At the time of writing, it is several months since Charlie's death and it is recognised that evidence of the impact of the above activity will, at best be in its infancy, as time is needed to both embed and evaluate new ways of working. SSCP will, in due course, need to determine the most appropriate way to seek and provide assurance about the impact of single agency learning.

7. Action timeline for implementation of learning and development.

7.1. A focused set of actions to take forward the learning been developed by agencies in Somerset as part of this review. They are set out below along with proposed timeframes.

7.2. As referenced at 1.9, there is synergy between the learning from this CSPR and the CSPR in respect of 'Alex' and a single set of actions has been agreed to take forward the collective learning in relation to the culture of partnership working and shared accountability and understanding of the various components of the health system; these can be found at 7.6 onwards.

ACTION TIMELINE

7.3. **Governance**

Review and clarify partnership governance arrangements for the strategic co-ordination of the multi-agency response to children living with domestic abuse.

Lead: CCG, Police and Local Authority SSCP Executive leads
Deadline: End of June 2021

7.4. **Multi-agency collaboration**

Consideration should be given to whether a regional approach to domestic abuse notifications should be developed in collaboration with Avon and Somerset Strategic Safeguarding Partnership (ASSSP). Implement a partnership approach to share information and analyse needs of children living with domestic abuse.

Lead: Chair of Partnership Business Group, SSCP/ Safer Somerset
Deadline: End of December 2021 to implement agreed approach.

7.5. **Whole Family approach**

Co-produce with frontline practitioners a partnership toolkit to equip practitioners to provide a whole family and safe outcomes focused approach to safeguarding children living with domestic abuse. The toolkit should be aligned with the Effective Support for Children and Families in Somerset framework and practitioners should be equipped to provide safe outcomes focused interventions to children and families living with domestic outcomes.

Lead: Public Health Specialist- Community Safety and Avon & Somerset Constabulary
Deadline: December 2021

7.6. The following actions have been agreed to take forward the common learning from this CSPR and CSPR Alex:

7.7. **Professional understanding of the health system**

Statutory partners to agree a programme of activity to develop a shared understanding of the different components of the health system and the contributions they can each make to information sharing, assessment and decision making; this should include emphasising the pivotal role of GPs.

Lead: Chair of Health Safeguarding Children Partnership, supported by a range of multi-agency partners as part of a workshop approach.

Deadline: End of March 2021

7.8. **Culture of partnership working.**

Recognising that cultural change is achieved over a sustained period, statutory partners through a weeklong Partnership Forum to explore the system conditions, including infrastructure, that will lead to strengthened partnership working and a shared accountability for improving outcomes for Somerset's children at all levels of the system. The outcome of the Forum should inform a cultural change programme which will involve all partner agencies.

Lead: Chair of Partnership Business Group
Deadline: June 2021.

February 2021