Coventry Safeguarding Children Partnership

Child Safeguarding Practice Review

‘Anya’

November 2023

Final V3

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Executive Summary

This Child Safeguarding Practice Review commenced after Anya, aged two years and two months, was found at home alone after her mother had sadly died in the family home. At the time of the incident, Anya was the subject of a child protection plan.

Over two days, various unsuccessful attempts had been made to gain access to the home by Children's Services - the local police force were requested to complete an urgent visit. Twenty-four hours later, Anya was found by police. She was physically unharmed although cold, wet and hungry. Family members have said that she continues to suffer with fears and nightmares associated with the trauma of this event.

There was a range of multi-agency services involved in supporting the family before and after Anya's birth. Multi-agency services were provided over thirteen years to support mother's care of her son, and latterly Anya. Concerns were centred on mother's misuse of alcohol and episodes of domestic abuse. The children suffered both acute and chronic neglect. Overall, the multi-agency response was characterised by responding to each crisis as it emerged – it was a reactive response that did not take account of the history of cumulative neglect.

The findings reflect the following key practice and service challenges:

- identifying and responding to neglect
- understanding the lived experiences of a child
- achieving integrated working across adults and children's services
- understanding and responding to the dynamic interplay of intersectionality
- paying attention to the language we use
- realising the potential of family and kinship in safeguarding children

Coventry Safeguarding Children Partnership have accepted the findings of this CSPR and are committed to implement the recommendations**.**

Introduction

Coventry Safeguarding Children Partnership (CSCP) were notified of a significant incident involving Anya aged two years and two months. Anya was found alone at home with her mother who had died. The Rapid Review[1] that took place following this notification concluded that the criteria for a Child Safeguarding Practice Review (CSPR) had been met and that a deeper analysis was likely to highlight important learning for the local area. The Child Safeguarding Practice Review Panel[2] agreed with this decision.

Methodology: This CSPR has complied with relevant guidance (Working Together to Safeguard Children 2018); relevant information has been supplied by agencies involved in providing services to Anya and her family; a panel of agency representatives, who had no direct involvement in the services provided, has met on several occasions and the perspectives of practitioners has been gained during a reflective learning event. Family members were asked to share their perspectives, Anya's maternal uncle (David) met with the independent lead reviewer (Bridget Griffin)[3], his perspectives are reflected in this report.

Scope: The scope of this CSPR covers a three-year period that includes Anya's mother's (Grace) pregnancy, Anya's birth and the care of Anya until the significant incident. The background of the family, including extensive multi-agency involvement with Grace and her son Nicolas, has been considered to inform the analysis.

Information and analysis: Information from multi-agency services has been gained through the submissions to the Rapid Review and independent management reports. Reflection and analysis has taken place during panel meetings and during the practitioner learning event.

The circumstances of the significant incident: Anya was the subject of a child protection plan shortly after her 2nd birthday – there were significant concerns about her mother's alcohol misuse. At an unannounced home visit by a Social Worker (SW) soon after an Initial Child Protection Case Conference (ICPCC), Anya was found in the sole care of her mother who was 'intoxicated'. A legal planning meeting was arranged, and daily visits followed. Over the next two days, Grace was found to be sober but on the third and fourth day, after trying on several occasions to visit the family, the SW received no response from Grace. The Police were alerted and were requested to undertake a safe and well check, a visit by the police took place the following day. At this visit Grace was sadly found dead in the family home, Anya was found alone in the house in her cot. The house was cold as all the windows had been left open, Anya was cold – her clothes were soaked in urine, she had a full nappy – it was clear she had not been changed for a significant amount of time but otherwise seemed physically unharmed. The post mortem concluded that Grace had died from ischemic heart disease, her time of death is unknown.

The Family: The family consisted of Grace, Anya, Anya's half – brother (Nicolas) and the birth fathers of Nicolas and Anya. Anya and Nicholas enjoyed positive relationships with a wide extended maternal family. The family are Black British, of Caribbean heritage.

[1] After notification of a significant safeguarding incident, local safeguarding children's partnerships may decide to convene a Rapid Reviews. The core functions of a RR is to; gather the facts about the case, as far as they can be readily established at the time, discuss whether there is any immediate action needed to ensure children's safety, share any learning appropriately and decide whether the criteria for a CSPR is met.

[2] Child Safeguarding Practice Review Panel

[3] Bridget Griffin CQSW, BA, MA

From the age of eleven, Nicolas was the subject of a Special Guardianship Order[4] (SGO) and lived permanently with his maternal grandmother in the local area. One year and five months after the application for a SGO was made, unborn Anya was made the subject of a child in need plan. Anya was born after Grace was induced due to concerns about growth retardation, she was born with no additional needs. On discharge from hospital, Anya was cared for by her mother in supported housing accommodation. Grace and Anya later moved to their own accommodation. Two months after Anya's birth, national restrictions were in place as a result of the coronavirus pandemic. Mother cared for Anya with support from maternal grandmother and professionals. The SGO in respect to Nicolas was granted when Anya was six months.

Nicolas and Anya's birth fathers did not live at the family home, there was sporadic contact between Nicolas and his father in his early years but no contact between Anya and her father. A male friend of Grace occasionally stayed at the family home. Aside from periodic episodes of domestic abuse, and police involvement due to use of drugs and alcohol in the household, little is known about the birth father's or the male friend. Maternal grandmother sadly died when Anya was eighteen months, Nicolas moved to reside with a maternal uncle (David) out of area. Family members based in London continued to provide support to Grace and Anya, they were concerned about Grace's long standing alcohol misuse and cared for Anya on several occasions.

Anya currently lives in London with a maternal aunt. David told the lead reviewer that Anya is settled in the care of his sister although he said that Anya still finds it difficult to sleep and of having nightmares when she will 'shake and scream'. He said that Anya often thinks that people are going to take her away and constantly craves attention. He recalled memories of Anya when she was living with her mother and described Anya as 'sometimes smiley' but also of being 'withdrawn and sad' and of 'rocking'. He described how painful it was to think of Anya and the trauma she has suffered and the unknown consequences of this trauma on Anya in the long term.

Summary of multi-agency involvement

There was considerable multi-agency involvement over many years. The Family Nurse Partnership provided significant support to Grace before and after the birth of Nicolas – there were concerns about mother's low mood, alcohol misuse and domestic abuse perpetrated by Nicolas's birth father. There were incidents when mother was arrested for affray, found drunk in charge of Nicolas and of chaotic and unsanitary home conditions. This led to intermittent involvement of the Police and Children's Social Care, and Nicolas was made the subject of child protection or child in need plans. Maternal grandmother provided extensive support to Grace and was noted to provide good care to Nicolas – there were no concerns about his development albeit in his younger years he was observed to bite, be clingy and hit out. Over this period there were regular meetings held under the universal or statutory frameworks, reviews of plans often took place. Mother was referred to domestic violence services and substance misuse services, incidents of domestic abuse were discussed at MARAC[5] and DASH[6] assessments completed. There was a pattern of Grace engaging and disengaging with services.

[4] A special guardianship order is an order appointing one or more individuals to be a child's 'special guardian'. It is a private law order made under the Children Act 1989 and is intended for those children who cannot live with their birth parents and who would benefit from a legally secure placement.

[5] MARAC (Multi-Agency Risk Assessment Conference) is a meeting where information is shared on the highest risk domestic abuse cases between representatives of various local services. The primary focus is to coordinate plans to increase the safety of the victim.

[6] The DASH tool (Domestic Abuse, Stalking, Harassment and Honour Based Violence Assessment) is part of the MARAC referral. It's a risk assessment that calculates the risk level for the victim.

When Anya was born, Nicolas was living with his maternal grandmother who was pursuing a Special Guardianship Order. Anya was induced as there were concerns about her growth being restricted, she was born with no additional needs. The pattern of multi-agency involvement, and the variable engagement of Grace, matched the historic involvement of services and this continued through Graces' pregnancy and after Anya's birth.

Timeline of key events: Anya

October 2019	Unborn Anya: Child in need plan
January 2020	Anya born
March 2020	Case closed to children's social care
April 2020	Domestic abuse and alcohol misuse. Multi - Agency Risk Assessment Conference (MARAC) Domestic Abuse, Stalking & Honour based violence assessment ((DASH) Initial Child Protection Conference (ICPC) – Child Protection (CP) plan – emotional abuse
July 2020	Review Child Protection Conference (RCPC) CP remains in place – Anya. Special Guardianship Order completed – Nicholas permanently in care of Maternal Grandmother (MGM)
June 2021	Child Protection plan ended
Sept' 2021	Anya removed to reside with relatives – Grace drunk
Nov' 2021	Grace removes Anya from relatives and returns to Coventry
Dec' 2021 – Jan' 2022	Family raise concerns – CiN plan
Feb' 2022	Strategy meeting and ICPC – Grace drunk, Anya child protection medical – concerns about lack of supervision – relatives care for Anya. Anya – on CP plan – emotional harm
March 2022	Anya found at home with Grace – Grace drunk
Later in March	Legal advice sought by CSC - legal panel arranged daily visiting – lack of response over two days – request police conduct a safe and well check
24 hours later	Police complete S&W check – Grace found dead, Anya at home

Key Findings

The findings identified in this CSPR are set out using the terms of reference agreed by CSCP.

1. Evaluate the effectiveness of inter-agency communication and information sharing.

Throughout the thirteen years of multi-agency involvement, information was shared between professionals, teams, agencies and panels across a wide range of services. Family support, CAF[7], Child in Need and child protection meetings took place within required timeframes and many referrals were made to an array of services to support Grace including housing providers, substance misuse, domestic abuse and mental health services. The question posed is whether the information sharing, and communication was effective. Although attendance by all agencies/services in the various meetings that took place was not consistent, taken as a

[7] The CAF (Common Assessment Framework) is a shared assessment and planning framework for use across all children's services and all local areas in England. It aims to help the early identification of children and young people's additional needs and promote co-ordinated service provision to meet them.

whole, there was a high level of information sharing and communication between the multi-agency services involved. However, whilst information was gained from agencies who were providing services to Grace in relation to domestic abuse or alcohol misuse, there was a lack of dialogue/effective communication across these adult services and between adult and children's services. The central question that is posed by this lack of effective dialogue is how the whole picture of the family, framed by the integrated involvement of both adult and children's services, was held in mind.

Taken as a whole, the involvement of both adult and children's services was characterised by responding to the presenting needs in the family at any one time - often in response to a crisis. Services were provided and referrals were made – the overriding response from services was to open and close involvement. The history of multi-agency involvement suggested that the vast array of services provided over thirteen years resulted in small improvements in mother's care of her children, but the overall pattern of mother's care showed that she was not able to sustain these changes - her chronic use of alcohol had not changed, and Anya continued to live in a household that featured sporadic incidents of domestic abuse.

The reasons why this position was reached is discussed in the following sections.

2. **Evaluate the appropriateness and effectiveness of how risk was understood and how safety planning was achieved**.

As highlighted in the previous section, many services were involved throughout the lives of Nicolas and Anya. In response to a crisis, when Nicolas or Anya was found in their mother's care when she was 'intoxicated' and/or the household was found to be chaotic and unsanitary, Nicolas, and later Anya, went to live with their grandmother/extended family members with agreement from the professionals involved. Safety plans were agreed and reviewed, and Grace was referred to relevant services. When incidents of domestic abuse were reported by police, referrals to domestic abuse services were made and immediate risk assessments and safety planning took place.

The pattern of the multi-agency response to safety planning for both Nicolas and Anya was a pattern of providing multiple services/making numerous referrals in response to a crisis or placing the children on child protections plans for periods of time, then stepping down service provision to a lower threshold of need followed by a further period of child protection planning and step down. There was a consistent pattern of Grace remaining sober for periods of time, attending some appointments with the alcohol misuse services and showing a willingness to engage with domestic abuse and mental health services, but overall there was a lack of meaningful change.

In time, this pattern was recognised as harmful to Nicolas and legal steps were taken to secure his care with family members. However, this historical pattern was not adequately considered when Grace was pregnant with Anya less than two years later, and multi-agency professional decision making was characterised by a false optimism. This seems attributable to a variety of factors including the lack of understanding of a child's experiences when living with a parent who is misusing alcohol, especially if the nature of addiction is binge drinking, or of appreciating the lived experience of a child living in households that feature domestic abuse – relevant issues are discussed in later sections.

Another important factor to consider when trying to understand why this position was reached relates to how multi-agency services assess and respond to risks when the source of harm is identified as emotional abuse. Both Nicolas and Grace were the subject of child protection plans at different times. Nicolas was first the subject of a child protection plan between the ages of three and six. Anya was the subject of a CP plan at 12 weeks and later when she was two. On these occasions, the concerns about parental care were the same including domestic abuse, alcohol use, and a chaotic/unsanitary home. On each occasion of child protection planning, the children were the subject of a plan under the category of emotional abuse.

Where there is domestic abuse and alcohol misuse, the research about the emotional impact on children living in these environments is clear. However, there are questions that arise about using this category to inform risk assessments and safety planning in these circumstances especially for infants. As with all categories of harm used in child protection planning, the impact of the harm must be considered according to each individual child (such as their age, developmental stage, additional needs, emotional needs and gender). Children's Social Care (CSC) are required to use one primary category when making a child the subject of a child protection plan. The primary harm suffered by Nicolas and Anya was both cumulative and acute neglect.

In Coventry the Graded Care Profile (GCP)[8] is used to assess and respond to neglect – this was not used until the most recent period of intervention. At this time it was recognised that whilst the primary source of harm was emotional, Anya was also experiencing neglect. The reason for not previously using the GCP may have been influenced by the historic pattern of conceptualising the primary source of risk as emotional harm, rather then neglect.

It is reasonably argued that the category in use makes no difference – it is framework and tools used to inform the assessment and plans that hold sway. In Coventry, the generic practice model in use is Signs of Safety[9] – the first priority in developing good practice in this model is stated as: *Creating a clear understanding of past harm, current harm, possible future dangers for child / young person (if nothing changes), and what the complicating factors to supporting the family are, means we can create better safety & well-being goals for everyone to work towards achieving.*[10] This model was in use in Coventry in 2015 – five years before Anya was born. This principle did not appear to be applied in practice until the most recent period of multi-agency child protection planning and intervention.

The Safeguarding Practice Review Panel[11] have recognised that…. *the recognition of cumulative neglect and its impact continues to be a key challenge for practitioners, with incidents of neglect too often treated in isolation. The use of evidence-based risk tools and assessments of parenting capacity can support practitioners in their assessment of neglect, ensuring a common framework and shared understanding between practitioners.*

In terms of Signs of Safety, quality assurance activity is showing that this model is embedded in practice in Coventry Children's Services. In terms of neglect, there is now a strong focus on neglect by CSCP. Better identification and response to neglect is a key priority for the partnership, a neglect strategy is in place, the GCP2 tool kit and training is in the processes

[8] Graded Care Profile 2 (GCP2) is an assessment tool that helps practitioners take a strengths-based approach to measuring the quality of care a child is receiving and supports them to identify neglect.
[9] The Signs of Safety® approach is a relationship-grounded, safety-organised approach to child protection practice, created by researching what works for professionals and families in building meaningful safety for vulnerable and at-risk children.
[10] https://www.coventry.gov.uk/lscb
[11] Annual Report 2020 Patterns in practice, key messages and 2021 work programme. Child Safeguarding Practice Review Panel 2021.

of being embedded across the partnership and multi-agency audits are in place. Therefore, no further development work is indicated in relation to the strategy, tools, training and quality assurance activity in place. Going forwards, the central learning from this CSPR suggests that there needs to be a better understanding of the link between emotional harm and neglect particularly in circumstances when there is a history of domestic abuse and/or substance misuse.

Recommendation 1. When considering the learning from this case, CSC to determine whether further development work is needed to consider the implications of using the emotional harm category in child protection planning, as opposed to the neglect category.

3. Identify if there were any key moments for escalation.

Over the period of multi-agency involvement with Anya, there were several opportunities to challenge the lack of effective action to effect meaningful change. Opportunities were available during the many multi-agency meetings that took place with a particular emphasis on the child protection case conferences and core group meetings. The lack of focus on the historic pattern of multi-agency involvement (which included an over focus on the separate incidents as they arose and a revolving door of statutory intervention) may account for this lack of escalation. There were occasions when a specific incident should have led to a collective review of the interventions to consider whether 'more of the same' was the right approach. Three specific occasions have been selected as an illustration of this.

The first occasion was when Anya was five months. A review child protection conference concluded that a child protection (CP) plan was not needed - the rationale was that Grace had consistently refused to complete the outstanding work and as there had been no reported contact with her male friend and no reported incidents of Grace misusing alcohol it was concluded that there was 'no evidence of significant harm'.

The second occasion was when Anya was 12 months and was removed from Grace's care by relatives due to Grace being so 'severely intoxicated' that she could not care for Anya. Anya was pre-verbal, bruises and scratches were seen on Anya which Grace could not account for. The conclusion of the CP medical was that this was likely due to a lack of supervision and Anya was made the subject of a CP plan for emotional harm. On both occasions, there was a known long-term history of Grace's misuse of alcohol, and of domestic abuse incidents – where consumption of alcohol was regarded as a key feature.
There was no effective challenge or questioning from any agency, panel, practitioner or manager about whether placing Anya on a CP plan for a second time would make any difference to Anya's lived experiences, or whether ending the plan, when Anya was five months, was the right decision.

The third occasion was on the day before the significant incident when police were asked to conduct an urgent safe and well check after CSC were unable to gain access to the home. Despite attempts by CSC to escalate this matter to achieve urgent action, Police visited twenty-four hours later. It is not known when Grace died - it was known that CSC had been unable to gain access to the family for two days.

Practitioners were clear that they were concerned about Anya and the harm she was exposed to at home, these concerns were discussed in supervision. Several practitioners spoke about the difficulties of evidencing emotional harm; of measuring/ quantifying the harm to a child and to be clear about the consequences – *emotional harm does not lead to an urgent response*

and there are no tools in use to assess and measure the harm. This may provide a partial explanation about the lack of effective challenge. However, it does not fully explain the absence of challenge in these circumstances. The Child Safeguarding Practice Review Panel have identified the lack of effective challenge and escalation as a key practice challenge.

Reviews frequently highlight a lack of 'professional curiosity' and 'over optimism'. Assessments and plans for support are framed by underlying assumptions that remain unchanged in spite of continuing or spiralling risk. This is particularly so where there has been intervention over a number of years. These circumstances are often combined with a lack of challenge between professionals and a reluctance to escalate concerns.[12]

The importance of collective multi-agency ownership of safeguarding decisions, actions and outcomes has been stressed in relevant guidance, national reports and child safeguarding practice reviews. Whilst CSC are the lead agency, CSC cannot safeguard a child effectively without the professional input and challenge from multi-agency partners. There was a great deal of input from multi-agency partners in the lives of Grace, Nicholas and Anya. The effect of an absence of challenge can lead to agencies acting as passive members of the multi-agency group with responsibility for making effective changes being left predominantly in the hands of CSC.

It is important to note that when there was challenge provided by CSC about the lack action by the police to complete a safe and well check in circumstances of serious concern, this was not treated with the seriousness warranted. This lack of an urgent response was referred to the Independent Office for Police Complaints (IOPC) and is currently the subject of a local investigation.

Recommendation 2: CSCP to consider what further service development work may be needed to promote the importance of multi-agency professional ownership and challenge in safeguarding children.

Recommendation 3. West Midlands Police to report findings of the IOPC and local investigation to CSCP, relevant multi-agency learning and action to be progressed with oversight from CSCP.

4. **Determine the extent to which agencies considered what daily life was like for Anya.**

Multi-agency services responded in a variety of ways to events in Anya's life (listed below). At times of crisis, Anya was cared for by relatives, when she wasn't - unannounced visits took place. There were occasions when Grace was noted to be 'sober' and Grace reported abstinence; breath tests were completed, and Grace reported compliance with acamprosate[13] medication. Child Protection activity took place; including three strategy meetings, two periods when Anya was the subject of a child protection plan and one period when she was the subject of a CiN plan. Core group meetings and CiN meetings took place.

However, an appreciation of Anya's lived experiences of these events, and of living with a mother who routinely misused alcohol in excess, was not evident: *Anya was lost.*[14] On occasions, Anya was noted to be hungry, of having a full nappy, of crying and of living in an unsanitary home. The question of what it may feel like for a child who lives in home where the only available adult was 'intoxicated' was not fully considered. The findings of a literature

[12] Child Safeguarding Practice Review Panel Annual Report 2022
[13] Acamprosate is an alcohol addiction treatment commonly used to reduce urges to drink and help people in recovery remain sober.
[14] Panel member

review completed by Research in Practice in 2013 remains highly relevant to contemporary safeguarding.[15] The following table draws primarily from this research and sets out the possible consequences for Anya.

Anya's Age	Event	Impact
In utero	Grace reported alcohol use to midwifery. Domestic abuse and alcohol misuse recorded x 2.	*Alcohol use, depending on its frequency and severity, can have an adverse impact on the health and development of the growing baby….Regular moderate use of substances is often less harmful than 'bingeing', as the sudden arrival of the substance in the baby's system followed by the subsequent withdrawal can place him/her at more risk….Alcohol exposure in utero was highly related to attachment insecurity.* Domestic violence research suggests exposure in utero can manifest in emotional and behavioural trauma symptoms in children within the first year of life.[16]
Birth	Induced due to concerns about restricted growth	*Alcohol is potentially the most harmful substance in terms of children's development as it impacts on the growth and development of the foetus affecting brain development at a critical time in the evolving foetal central nervous system.*
2 weeks	Maternal depression	At 2 weeks a baby has become increasingly aware of sensory input – a care giver who is depressed may be unable to respond/ their mood may be flat.
10 weeks	Domestic abuse and alcohol misuse	*Substance misuse can sometimes be accompanied by violence in the home, the physical risks to children and young people may increase.* *Alcohol misusing mothers have been shown to be less responsive to the child's signals, less willing to involve themselves in the meaningful play that is crucial to educational and cognitive development and be potentially more likely to respond in a manner that is curt rather than facilitative. This lack of attentiveness may result from parents' pre-occupations with their own anxieties or feelings, or the impact of alcohol or withdrawal from alcohol causing hyperactivity or impatience.* The developing brain is most vulnerable to the impact of traumatic experiences during this time. Research on brain development suggests that exposure to extreme trauma will change the organisation of the brain, resulting in difficulties in dealing with stresses later in life.
5 months	Multiple attempts made by HV/GP to see Anya surgery – for immunisations, & developmental check.	*Parents may neglect their own and their children's physical care, and levels of hygiene and cleanliness may suffer. Routine health checks may be missed.*
16 months	Grace was found to be heavily intoxicated and passed out – the front door was open – there was no food in the fridge. Relatives care for Anya	*Being left alone or unsupervised while parents are intoxicated or under the influence of drugs potentially places children at risk and a parent's need for the substance can become the primary focus.*
17 months	Grace returns Anya to her care	*The motivation and energy to deal with the demands and challenges of an inquisitive and alert child can be adversely affected by the stresses and structural pressures that either precipitate substance misuse or are the result of it …..* *Substance misuse affects 'the shape of the family and its everyday rhythms due to its impact on rituals and daily functioning.*
18 months	Family members continue to raise concerns about Grace drinking excess alcohol**.**	*Parents' preoccupation with the substance, to the exclusion of other priorities, will have a range of consequences for children's sense of emotional security. An unavailable, preoccupied or emotionally, psychologically and physically detached parent will find it difficult to keep children in mind or put them first. Changes in mood and behaviour, together with inconsistent responses and lack of empathy, will make life uncertain and anxiety-provoking at the very least. If the primary attachment is to a substance, this will affect a capacity to attach to others - the main impact on children is a strong sense of not coming first, as well as feeling unloved and unwanted.*
2 years	Home 'very untidy and cluttered' - empty bottles of vodka noted	*When parents' behaviour is unusual, inconsistent, worrying or frightening, small children find it hard to put their fears and anxieties into words and these therefore manifest themselves in ways akin to the signs of post traumatic stress disorder.[17]* *Lack of routines can increase distress and uncertainty.*
2 years	Grace found to be 'intoxicated' with Anya in her care – property 'dirty and smelt'. Anya cared	*Barnard and Barlow (2003) describe children's situation as like a 'world of mirrors' where children's distorted reality affects not only their ability to disclose but also their ability to 'know' – a pre-requisite for disclosure. Parents' capacity to anticipate*

[15] *The impact of parental substance misuse on child development.* Research in Practice, Dartington 2013
[16] Postnatal maternal depressive symptoms and behavioural outcomes in term-born and preterm-born toddlers: a longitudinal UK community cohort study. Kleine et al. BMJ Vol 12 Issue 9 2021

	for by family members who noted bruising and scratching – CP medical concluded – lack of supervision	*the particular dangers presented by inquisitive children requiring especial vigilance may be blunted.*
2 years & 2 months	Family member raised concern about Grace drinking – SW visit – Grace 'intoxicated' and Anya crying. House untidy – no food in the home – Anya hungry	*When parents' behaviour is unusual, inconsistent, worrying or frightening, small children find it hard to put their fears and anxieties into words and these therefore manifest themselves in ways akin to the signs of post traumatic stress disorder …Lack of routines can increase distress and uncertainty.* *Additional risks relate to the dangers of copying substance using behaviour, either as simple imitative behaviour in small children, or as a problem solver.*
2 years & 3 months	CSC unable to gain access to the home/ response from Grace for 2 days – on the third day police find Grace dead. Anya was in the home – she was in her cot – she was not crying and seemed unharmed.	*When children view their parents as untrustworthy or powerless they may react by withdrawing or trying to please (Cleaver et al, 2011)* and may be *unnaturally quiet.*

In summary, available research suggests that children whose only care giver is emotionally and physically unavailable poses significant risks to the child's emotional and physical wellbeing. The physical risks such as accidents, hunger, and coldness are obvious. The less obvious risks require closer attention – these include less response from their parent, less willingness to engage in play or encourage interaction, periods of loneliness and isolation, exposure to behaviour from their care giver that may be irrational, unpredictable or withdrawn which may be frightening. For small children – these feelings can become deeply ingrained forming part of normal life in their crucial early development – part of who they are and who they will become. The short- and long-term consequences of these formulative experiences are saturating, and far reaching. *They can experience loneliness, depression, anxiety, guilt, anger issues, and an inability to trust.*[18]

Understanding the daily life of a child has been identified by the Child Safeguarding Practice Review Panel[19] as a key practice theme that requires ongoing attention by practitioners and services. *Understanding what a child sees, hears, thinks and experiences on a daily basis, and the way this impacts on their development and welfare, is central to protective safeguarding work. … The child's views should inform analysis and assessment so that intervention is appropriate to address key concerns and needs.* For small children such as Anya, especially for those children who have lived with trauma, practitioners need to interpret what they are seeing/ what they know about the family circumstances and consider the impact on a child's daily experiences - thereby becoming the child's voice. As identified by the national panel, the complexity of situations can lead to a focus on parental needs. This was evident in this case and was a key concern for David – his perspective was that the views of, or self-report by, Grace was given too much weight.

A further important practice area that seemed to divert services and practitioners from hearing Anya's voice was the language used. The following words were routinely used in multi-agency records: Grace was *intoxicated.* Anya has *a good attachment with her mother.* Anya was *safe and well.* Use of these words, rather than describing what was observed, minimised and

[18] https://learning.nspcc.org.uk/children-and-families-at-risk/parental-substance-misuse

[19] Annual Report 2020 Patterns in practice, key messages and 2021 work programme. Child Safeguarding Practice Review Panel 2021.

distracted from Anya's lived experiences. Questions such as what did 'intoxicated'/'good attachment' look like – how did Anya respond – what is conjured up when using words such as 'intoxicated', 'good attachment', 'safe and well' ? As identified by panel members and members of the Rapid Review: *Language that is used can desensitise and minimise the level of risk. Language shapes professional narratives about families.*

Describing what is observed, evokes a clearer view of a child's experiences. Describing a 'good attachment' after one brief observation is of particular note - using this language to describe the relationship between a care giver and a child induces powerful assumptions about the wellbeing and safety of a child and should be avoided - assessing attachment is a specialist undertaking. In conclusion, the use of language has important implications for safeguarding work – it can lead to assumptions being made and frame the service response. As identified by the NSPCC – safeguarding practice can be improved by simply paying attention to the language that is used.[20]

Recommendation 4. CSCP to raise awareness of the importance of paying attention to the language used in safeguarding work during relevant training, awareness campaigns, through supervision and audits. Findings to be reported to CSCP to consider what further action may be needed.

Recommendation 5. CSCP to determine what further work may be needed to support multi-agency practitioners in understanding/interpreting and recording a child's lived world with particular reference to children living in households where there is domestic abuse and/or substance misuse.

5. **Evaluate the extent to which father and extended family members were engaged by services in risk assessment and safety planning.**

When Nicolas was living with his mother, the multi-agency professional group were clear that maternal grandmother represented an intrinsic source of safety and support for Grace and Nicolas. Practitioners, in particular the Social Worker and the Family Nurse Partnership practitioner, worked hard to hear her voice and engaged Grace well in gaining her consent to share information with maternal grandmother and involving her in the professional network. Over Nicolas' early childhood, this resulted in a shared care arrangement between mother and daughter. Maternal grandmother often raised concerns about her daughters use of alcohol, her concerns were heard and responded to. Overtime, this led to formalising her care through a Special Guardianship Order.

There was less evidence of maternal grandmother being seen as an intrinsic member of the network before and after Anya was born. Maternal grandmother sadly died when Anya was eighteen months. Two months later, family members removed Anya from her mother's care when she was found to be drunk and incapable of looking after Anya. Family members made immediate contact with the Coventry Children's Service (CCS), and the local children's service where they lived, raising concerns. A written agreement was drawn up between CCS and family members with the intention of securing Anya's residency with a maternal aunt. During the following weeks, the advice provided to family members was confusing. The advice from the local children's service was that maternal aunt should 'apply for private fostering', maternal aunt started the process of registration to be told that as Anya was living with her under a written agreement made by CCS – it was for CCS to assess the circumstances and provide support – this was correct. A month later, CCS child and family assessment concluded that maternal aunt 'should apply for private fostering'.

[20] *Why language matters – improving safeguarding and child protection with words*. NSPCC 2023

One month later, Grace removed Anya from the care of maternal aunt – there was nothing maternal aunt could do to stop her from taking this action. The advice that maternal aunt should 'apply for private fostering' was incorrect – private fostering is simply about registering a private care arrangement, not applying for a formal caring role, and comes with minimal oversight from statutory agencies – removing a child from this arrangement is at the complete discretion of the birth parent. Under a written agreement, arrangements are based on agreement between parties, there is often no legal underpinning/framework. It is unclear what contingency plans were in place in the event of Grace removing Anya from this arrangement. If there were contingency plans, such as seeking to formalise the arrangement through legal proceedings, these were not enacted.

During the following months, family members continued to raise concerns about Grace 's alcohol consumption and their worries about Anya. CCS found Anya at home with Grace who was 'intoxicated', and maternal aunt resumed care. Again, Anya was removed by Grace as there was no legal order in place to secure her in the care of maternal aunt. This pattern repeated over the following weeks until the significant incident. Whilst CCS responded to the concerns expressed by family members, the response to the gravity of family concerns was not matched by the action that was taken. There were several opportunities to provide a response that secured Anya's safety by taking the necessary legal action in the form of a emergency protection order &/or an interim care order[21] and place Anya under a Regulation 24 arrangement[22] with maternal aunt. For David, and other family members who attempted to safeguard Anya at this time, this lack of legal action was felt to be a significant failing that resulted in Anya suffering unnecessary trauma.

Recommendation 6. CSCP to seek assurances, including evidence of outcomes, from CCS that practitioners and managers are fully aware of private fostering regulations, the limitations of written agreements and the legal steps required to secure a child with connected carers where there are concerns about a child's safety.

It is understood that in Coventry Children's Services (CCS), child protection chairs and quality assurance managers do not have access to legal advice and are not permitted to be part of the legal discussions or have access to 'privileged information' that is shared as part of these legal consultations. If child protection chairs are to provide effective oversight and challenge of safeguarding activity, this seems to be an important area requiring further consideration in CCS.

Recommendation 7. Contingency planning that includes legal action to safeguard a child should form a consistent part of the child protection plan. The involvement of child protection chairs in legal consultations and planning meetings should be reviewed.

In terms of the birth father's of Nicolas and Anya – there was some contact with Nicolas's birth father by the multi-agency group when Nicolas was a young child but none with Anya's birth father. Overall, there was little attempt to understand, beyond the maternal narrative, what part they played in the lives of Nicolas and Anya. The NSPCC invites us to consider the language we use when referring to men who out of view of multi-agency services, rather than referring to them as 'hidden' or 'invisible' – fathers/father figures should be referred to as being

[21] Interim Care Order (Sc38 Children's Act 1989). At the start of care proceedings, a temporary court order (an interim care order) can be granted.
[22] Regulation 24 of the Care Planning, Placement and Case Review (England) Regulations 2010 allows a child to be placed in the immediate care of a connected person whilst an assessment progresses.

'unseen' by services. It is encouraging to note that Nicolas' father has now been 'seen' and contact between father and son has been established.

The recent government response to the Independent Review of Social Care[23] – Stable Homes Built on Love[24] emphasises the importance of fully involving families in the care and safety of children. Multi – agency services are a key partner in achieving the proposed government vision and considerable service development work is emerging in Coventry and across the country. The conclusion of the recent consultation about the new government strategy is awaited.

Recommendation 8: Learning from this CSPR, about the need to promote an equal partnership of father's and extended families in safeguarding children, should inform future service design/ developments to achieve the new government strategy. CSCP to maintain oversight.

6. Determine how the historic concerns about maternal alcohol misuse were considered in assessments and safety planning.

After a review of the information provided to this CSPR, it was concluded that this CSPR should explore how historic and recent alcohol misuse and domestic abuse were considered in assessments and safety planning.

Reports of alcohol misuse were documented in multi-agency records throughout Nicolas' life. When Grace was pregnant with Anya, she reported use of alcohol during her pregnancy. Historic and ongoing concerns about alcohol misuse led to Anya being the subject of an unborn CiN plan. Grace was induced as a result of concerns about Anya's restricted growth. Anya was ten weeks when an incident of domestic abuse was responded to by police and concerns about the misuse of alcohol were recorded. A DASH assessment concluded that Grace was at high risk of domestic abuse and MARAC linked the domestic abuse with alcohol consumption by both parties. Grace was referred to relevant domestic abuse and substance misuse services.

During a child protection investigation (Sc47 Children's Act 1989), information was gathered from multi-agency services and Anya was made the subject of a CP plan under the category of emotional harm – the plan included the need for Grace to engage with domestic abuse and substance misuse services. Two months later, at the Review Child Protection Case Conference (RCPCC), Grace reported that she was not in contact with her partner and was not drinking alcohol. It was acknowledged that Grace had not engaged with the relevant services but as there had been no further reports of domestic abuse or substance misuse it was concluded that there was no current evidence of significant harm and Anya was removed from a CP plan. Three months later, a family member reported that Anya had been removed from Grace's care as she had been found 'heavily intoxicated' and had 'passed out' whilst caring for Anya. A Sc47 investigation concluded that whilst there were concerns about alcohol misuse – Anya was not judged to be at risk of continuing harm as she was safe in the care of family out of area. One month later, Grace returned Anya to her care. Six weeks later, family members raised concern about Grace's misuse of alcohol. A Child and Family assessment

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commenced and concluded recommending a CiN plan. During this time, medical tests confirmed changes in Grace's liver which could be related to excess alcohol consumption.

Three weeks later, Anya was found at home with Grace who was 'intoxicated' – CCS arranged for Anya to be placed in the care of family members. A Sc47 investigation and child protection medical concluded with an outcome of lack of supervision and Anya was made the subject of a CP plan under the category of emotional abuse. Substance misuse services were actively involved with Grace who reported abstinence and compliance with acamprosate medication. During the following weeks, concerns about Grace's alcohol use continued until the significant incident.

The response by multi-agency services raises several issues.

The involvement of multi-agency services over thirteen years was primarily triggered by domestic abuse incidents, where alcohol misuse by Grace and her partners was concluded to be an aggravating factor and included incidents of Grace being intoxicated whilst caring for Nicolas and later, Anya. Misuse of alcohol by mother in Nicolas's childhood was the primary reason why a Special Guardianship Order was made. When Anya was born, maternal alcohol use was considered as a possible cause of growth retardation, but this was not shared with the multi- agency network. When Anya was the subject of a CP plan in the early months of life, alcohol misuse and domestic abuse were recognised as the primary cause of harm. The pattern of critical incidents sparking the involvement, and ending, of statutory service involvement followed the same pattern for Anya as it had for Nicolas. The reason for this appeared to stem from a number of factors:

Reliance on maternal self report. There was an overreliance on Grace's account of her alcohol use, these accounts were not triangulated by sufficient objective evidence from health services such as her GP or from routine objective testing that should have been an expected requirement from the substance misuse service. Concerns expressed by family members about her drinking patterns were not sufficiently explored or regarded with enough gravity.

Lack of understanding about the nature of binge drinking. Binge drinking is characterised by periods of being sober and periods of excessive drinking. It does not necessarily mean a person is suffering from alcoholism. Grace said *I am not an alcoholic – I am a binge drinker*, a possible consequence of this perspective meant that her engagement with services provided by the substance misuse service varied; there were times when she engaged with this service and times when she did not. Her engagement seemed to mirror the pattern of her binge drinking. There was a false optimism that her engagement with a fifteen-week substance misuse course had provided the necessary treatment – Grace abstained from alcohol for a period, but the pattern of binge drinking returned. The thirteen-year history of this pattern was not given sufficient consideration. The history, supported by the medical evidence, strongly suggested that Grace was suffering from a chronic alcohol misuse disorder and that this was unlikely to change in the short term. This had significant implications for Anya's safety and wellbeing, and serious health implications for Grace.

Lack of a integrated approach between children and adult services. The response to Grace 's alcohol use was to respond to crises as they arose; once the crisis had passed – concerns receded, and statutory intervention ceased. This response continued throughout multi-agency intervention. The medical information held by the GP did not seem to influence this stop start approach. Substance misuse services were sometimes involved in professional meetings, but their attendance was inconsistent. There did not appear to be an opinion offered either by the medical professionals involved or by the specialist substance misuse service about the possible aetiology, the prognosis, or the likely effect on Anya of her mother's alcohol

use. As a result, Children's Social Care were left to make sense of the information and, in the absence of effective challenge about the approach being taken, they were left in relative isolation to determine the risks.

Recommendation 9: When safeguarding children from domestic abuse and/or substance misuse, the information held in relevant services, including GPs, must be routinely available to CSC. A lack of consistent proactive engagement in safety planning by relevant services, including providing information to triangulate the evidence used to inform child protection plans, must be routinely escalated.

The language used that minimised concerns. As identified in section 4, it is important to pay attention to the language used in safeguarding work. The words 'substance misuse' and 'intoxication' was used throughout multi-agency records, the view of the Rapid Review and panel members was that routine use of these words minimised the risks to Anya and Grace. It was felt more accurate to describe what is observed with a focus on the impact for the child - be curious about what it meant to Anya when her mother was 'intoxicated': What did intoxication look like? How did Grace behave – was she happy, loving, sad, angry irrational, forgetful, accident prone? How did Anya respond, and what was the likely impact at her stage of development? Speaking to family about this could have provided some helpful descriptions.

Understanding and responding to domestic abuse: The Child Safeguarding Practice Review Panel (CSPRP) briefing[25] highlights areas of practice that require attention. Several of these factors were evident in the response to the domestic abuse in this case. The CSPRP identifies that despite the widespread evidence of the multiple negative impacts of domestic abuse there was a notable absence of children's voices - services were aimed at mother as the victim. In this case, whilst there had been no recently reported incidents of domestic abuse there had been a long history of domestic abuse incidents involving two male partners. The last reported incident of domestic abuse led to a visit by the Police who reported Anya was 'safe and well'. The DASH assessment concluded Grace was at high risk of domestic abuse.

Over the period of multi-agency involvement DASH assessments took place, MARAC discussed the incidents and Grace was referred to relevant domestic abuse services – Grace did not engage with these services. Nicolas's father was offered an anger management course which he did not take up. Grace's male partner, who she was in a relationship with when Anya was in her care, was not included in the intervention by domestic abuse services. The CSPRP highlight that there is a lack of response to those who cause harm (92% of which were men) – it was the mother/female partner who was expected to be the catalyst of change/to engage. The CSPRP set out four interlinked and independent core principles that should underpin responses to domestic abuse: *Domestic abuse informed, trauma informed, whole family and intersectional.*

Recommendation 10: Domestic abuse services in Coventry and West Midlands police to demonstrate how the voice of the child, in cases of domestic abuse, is understood and reflected in service provision and clarify the services available to perpetrators of domestic abuse. CSCP to provide support and challenge based on the four core principles set out by the Child Safeguarding Practice Review Panel.

Engagement: There were concerted and persistent attempts by practitioners to engage Grace in service provision. There were periods when Grace's engagement was achieved and periods when it was not; there were small gains, but the history suggested that engagement in key

[25] *Multi-agency safeguarding and domestic abuse*. Child Safeguarding Practice Review Panel Briefing 2 September 2022

areas (that would have made a meaningful difference to Nicolas and Anya) was not achieved. The Child Safeguarding Practice Review Panel identify as a key theme: Working with families where their engagement is reluctant and sporadic. *It is important to understand the underlying issues giving rise to reluctant or sporadic engagement, particularly where professionals are 'working with consent'.* Understanding the reasons behind Grace's sporadic involvement required greater attention with a particular emphasis on her lack of consistent engagement with substance misuse, domestic abuse and mental health/emotional wellbeing services. Questions about what may lie at the heart this inconsistent engagement needed to be respectfully explored.

Intersectionality: Grace was a Black British woman of Caribbean heritage, the impact of intergenerational experiences of discrimination, including possible feelings of shame that can be a result of racism, and intergenerational experiences of involvement by statutory services, including mental health services, needed to be held in mind and respectfully explored. Multi-agency records did not demonstrate how this was considered as a possible factor that may have influenced Grace's engagement with services.

Research reveals there can be a lack of trust in these services resulting from experiences of discrimination – black and ethnically diverse communities are overrepresented in prisons, the criminal justice system[26] and intergenerational experiences of mental health services are important to understand. *People in Britain from BAME communities face fundamental inequalities in access to treatment, experiences of care and outcomes from mental health services.*[27] In addition, relevant research about access to substance misuse services highlights that there are *barriers to effective treatment for BAME clients that may interfere with them starting, completing or engaging in treatment.*[28]

Coventry Council has in place an Equalities, Diversity and Inclusion (EDI) policy which sets out five core principles underpinning the council's approach.[29] Safeguarding Children's Partnerships have built on such EDI policies to support practitioners in exercising cultural competency in their work and this approach has been embedded in multi-agency safeguarding training. [30] It is suggested that CSCP build on this approach by promoting cultural competency/ 'social graces'[31] as a practice principle in multi-agency safeguarding work.

Recommendation 11: CSCP to review how cultural competency/ social graces are promoted as a practice model in relevant CSCP policies, training and supervision with particular reference to how engagement with families is understood and achieved. Single and multi-agency audits to routinely include this as an audit variable and report to CSCP on outcomes to inform any future service developments.

Impact of the coronavirus pandemic

During the period of multi-agency involvement with Anya, the pandemic and resulting national restrictions happened two months after Anya was born. Anya was 3 months when she was made the subject of a child protection plan, and there was multi-agency involvement in various forms over the entire period of the pandemic. There was an evident impact of the pandemic on the services provided which included a reduction in face-to-face contact and an overall reduction in some services due to staff sickness and the need to divert services to deal with

[26] *National statistics. Ethnicity and the Criminal Justice System, 2020*. Ministry of Justice. Published 2 December 2021
[27] https://www.solentmind.org.uk/news-events/news/mental-health-matters-video/
[28] *The effectiveness of rehabilitative services for Black, Asian and Minority Ethnic people: a rapid evidence assessment.* HM Prison and Probation Service. Ministry of Justice 2018
[29] https://www.coventry.gov.uk/equality-diversity-coventry/equality-diversity-1
[30] https://thebarnetscp.org.uk/bscp/news/bscps-cultural-competency-practice-statement
[31] https://www.basw.co.uk/media/news/2020/jul/social-graces-practical-tool-address-inequality

the impact of the crisis. It is also important to appreciate how the pandemic may have impacted on Grace. Grace 's mother died during the pandemic, feelings of isolation, anxiety and a lack of human connection may well have had a significance influence on Grace and Anya.

Conclusion

A multitude of services and agencies were involved in safeguarding Anya and Nicholas. Overall, processes were followed and there were many attempts to provide the services needed to make a difference. The Covid Pandemic was an important systems dynamic that featured during the central period of multi-agency involvement with Anya and undoubtedly had an impact on this family and on the services provided. The importance of understanding family histories, how engagement with services is influenced, and the critical partnership that is achieved with adult services with fathers and extended families is highlighted as key learning. Recommendations have been made to support Coventry Safeguarding Children Partnership (CSCP) to put the learning into practice, some of which are easier to achieve then others and some of which relate to contemporary safeguarding challenges that are being grappled with across the country. In completing reviews such as this, CSCP demonstrate their commitment to better understand the lived experiences of children and families and use this knowledge to strengthen the way children are safeguarded.