



Serious Case Review

Child N

FINAL

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1 INTRODUCTION

- 1.1 This Serious Case Review was conducted under the statutory guidance of Working Together to Safeguard Children 2013 which applied at the time of the initiation of this review which states (page 68) that a serious case review should take place “ . “where abuse of a child is known or suspected; and -either - (i) the child has died; or (ii)the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child” .
- 1.2 The subject of this Serious Case Review (SCR) is Child N.
- 1.3 Child N died in December 2012 aged 13 months.
- 1.4 This Serious Case Review focused specifically on how agencies worked together and individually between March 2011 and December 2012.
- 1.5 Child N’s mother (MCN) called an ambulance just before 6am on the day of her death in December 2012 as Child N was in a lifeless state. Paramedics who attended Child N at the family home observed blood and faeces on the stretcher sheet on arrival at the hospital. The doctor who attempted to resuscitate Child N at the hospital where she was taken by the paramedics observed blood coming from Child N’s anus.
- 1.6 The then Coroner ordered an Inquest into Child N’s death. An Inquest occurs when a death appears to be from unnatural causes or has occurred under suspicious circumstances. A short Inquest was held in October 2014, and the cause of death was recorded as ‘unascertained’. Following the appointment of a new Coroner in the case, an application for a new Inquest was made by the Senior Coroner for Cumbria. This was granted. Subsequently, in late July 2015 the Coroner announced that a further Inquest would be held and this will take place in the autumn of 2016.
- 1.7 Post mortem x-rays carried out 2 days after Child N’s death revealed healing fractures to Child N’s tibia and fibula. The post mortem also revealed other possible injuries to Child N. As discussed in the previous paragraph, a second Coroner's Inquest is awaited.
- 1.8 No prosecution has taken place but the Crown Prosecution Service is still considering this decision.
- 1.9 Child N’s genealogy is extremely complex. As a brief summary:
 - MCN’s first Child had been removed from her mother’s care in 2002 and was subsequently adopted in 2004.

- MCN's second child (Child 2) was born in 2003 when MCN was 19 years of age and care proceedings were issued. Child 2 was placed with MCN at home. The placement was successful and the care order was discharged in 2007.
- Child N was a twin and she and her sibling were the 6th and 7th children of MCN.
- 6 of MCN's 7 children were living with her at the time of Child N's death.
- It is possible that MCN was sexually exploited at the age of 15.
- MCN had been a looked after child herself because she was at risk of Child Sexual Exploitation
- MCN became pregnant at the age of 15 in 2000 with her first child when she was still the subject of a care order.
- Child N's father, FCN was also the father of MCN's 5th child as well as Child N and her twin and had 2 older children with 2 different partners.
- Agency records showed that MCN and FCN began living together in 2010 (however this was disputed by MCN prior to publication of this report).

1.10 At the time of the Child N's death, agency records showed that MCN and FCN were living together, however MCN and FCN separated frequently and on these occasions FCN left the family home.

1.11 From 2007, the date at which the care order on Child 2 was discharged, to the time of Child N's death, neither she, nor any of her siblings who were living in the household, were subject to statutory intervention by the local authority and MCN and FCN appeared to care for them all satisfactorily. There were no concerns reported by health visitors, the GP or schools to social care.

2 METHODOLOGY

2.1 At a special meeting of the Cumbria Local Safeguarding Children Board (LSCB) Case Review Panel on 4th February 2014, Child N was discussed and it was deemed that the criteria for commencing a SCR were not met. This was accepted by the then Chair of the LSCB.

2.2 This case was subsequently referred to the new incoming Chair of the LSCB in March 2014 following a Finding of Fact in care proceedings. The Finding of Fact was made available to the LSCB Chair at that time, but was not published until January 2016 following a second Finding of Fact, which was published alongside the first Finding of Fact. A Reporting Restriction Order was, and still is, in force in relation to these. As a result, this case was re-considered at a

special meeting of the Case Review Panel in May 2014 and the Panel recommended to the LSCB Chair, who was in attendance, that the SCR criteria had not previously been applied correctly and that the criteria for commencing a SCR was met. On the same day this was agreed by the LSCB Chair and this review was then commenced.

- 2.3 The LSCB Case Review Sub Group made a recommendation that the LSCB should conduct a proportionate, appropriate and importantly **participative** SCR with the emphasis upon professional involvement, to address how agencies had worked together in this case, identify any learning, aggregate lessons from individual organisations and ensure that an improvement action plan was put in place.
- 2.4 The SCR was designed and led by Clare Hyde MBE, independent reviewer, from The Foundation for Families (a not for profit Community Interest Company). Ms. Hyde developed a review model that would enable participants to consider the events and circumstances, which led up to the tragic death of Child N.
- 2.5 The analysis in this report uses some elements of the framework developed by Social Care Institute for Excellence (SCIE) to present key learning within the context of local systems. This also takes account of recent work that suggests that an approach of developing over prescriptive recommendations have limited impact and value in complex work such as safeguarding children. For example, a 2011 study of recommendations arising from serious case reviews 2009 - 2010, (Brandon, M et al), calls for a limiting of 'self-perpetuating and proliferation' of recommendations. Current thinking about how the learning from serious case reviews can be most effectively achieved is encouraging a lighter touch on making recommendations for implementation rather than over complex action plans.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/184053/DFE-RR226_Report.pdf
- 2.6 An Expert Leads Panel was convened of senior and specialist representatives from LSCB agencies, to oversee the conduct and outcomes of the review. All panel members were independent of the family and casework. The role of the panel was to assist the lead reviewer in considering the evidence, formulating the recommendations and quality assuring this report.
- 2.7 Agencies involved with Child N and/or her family members were asked to provide a chronology and these were integrated into a combined chronology by the Cumbria LSCB Business Support Team. Some of this information was

background information prior to the review period. The following agencies provided a chronology:

- Cumbria Police previous involvement prior to the period covered by the review
- Schools (in respect of the siblings)
- North West Ambulance Service (NWAS) (involvement on the day of Child N's death)
- GP Medical Practice
- Cumbria County Council - Children's Services (involvement until 2007.
- University Hospital Morecambe Bay Trust (UHMBT)
- Cumbria Partnership Foundation Trust (CPFT):
 - School Nursing
 - Health Visiting

2.8 The author of this report considered the joint chronology and met with the multi-agency group of professionals involved with Child N to consider in detail the sequence of events and key practice episodes that underpinned those events. The SCR was commissioned by Cumbria LSCB in line with its statutory reviewing functions as defined in 'Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children' (2013)¹.

2.9 It was agreed that the period of time covered by the SCR would be from the date that MCN's pregnancy with Child N was known to agencies which was March 2011 up to December 2012 which was the date of Child N's death.

2.10 The LSCB Case Review Group agreed specific terms of reference that provided the key lines of enquiry for the SCR in addition to the terms of reference described in national guidance. The key lines of enquiry included in the terms of reference were:

- A. Did any agency recognise and assess risk in respect of Child N or any of her siblings?
- B. What, in this case, reassured practitioners that Child N was safe and well?
- C. Were any signs of abuse missed by practitioners?
- D. What can we learn from our response to Child N and her family?
- E. Was the parenting capacity of Child N's parents assessed effectively?
- F. How well was information shared, understood and responded to between agencies?

¹ Superseded by Working Together 2015 (published after this review commenced)

- G. What did we do? What should we have done? What could we have done?
- H. What tools have we got? How do we apply them?
- I. Supervision and management: what do practitioners need when working with families like Child N's?

2.11 The panel established the identity of services in contact with the family during the time frame agreed for the review. These agencies were the family GPs, midwifery service, health visiting service, the accident and emergency service, secondary health services (audiology) and the school nurse.

2.12 The SCR aimed to provide an innovative 'whole system' approach involving key front line practitioners (and their line managers) who worked with Child N, her siblings and adults of Child N's family in a learning event held in November 2014. In this way, Child N's 'story' was to be central to the Learning event.

Independence

2.13 An independent chair, Jon Rush (Lay Member from the LSCB) was appointed by the Local Safeguarding Children Board to chair the Expert Leads Panel.

2.14 The lead reviewer was Clare Hyde MBE. As previously stated, Ms Hyde is founder and Director of The Foundation for Families, a not for profit community interest company established in 2010. Ms Hyde was CEO of Calderdale Women Centre for 14 years (between 1994 and 2009) and developed nationally acclaimed, high quality services and support for at risk women and families. Ms Hyde contributed to Baroness Corston's review of women with vulnerabilities in the criminal justice system which was commissioned by the Government following the deaths of several women in custody.

2.15 Ms Hyde is currently working with LSCBs and their partners to improve safeguarding outcomes for children and young people living with domestic violence, substance misuse and parental mental illness and to support the development of a multi-agency response to children and young people at risk of sexual exploitation.

2.16 Ms Hyde also designed and facilitated a multi-agency review of child sexual exploitation in Rochdale in 2012 and is currently the Independent Chair of several SCR's and a Domestic Homicide Review and has designed and led several Learning Reviews on behalf of local safeguarding children and adults boards.

Expert Leads Panel

2.17 The Expert Leads Panel met on a number of occasions between June 2014 and March 2016. The overview report was ratified at the LSCB meeting on 5th May 2016

2.18 The Panel comprised of:

Title	Organisation
Panel Chair	Lay representative from Cumbria LSCB
Senior Manager	Cumbria LSCB
Designated Nurse	Clinical Commissioning Group (CCG)
Lead General Practitioner (GP) for Safeguarding Children	CCG – Primary Care (Also representing Cumbria Health on Call (CHOC))
Assistant Director – Children and Families	Children’s Services
Interim Designated Doctor	CCG
Crime Commander	Cumbria Constabulary
Clinical Service Manager	Cumbria Partnership Foundation Trust (CPFT)
Named Midwife for Safeguarding	University Hospital Morecambe Bay Trust (UHMBT)
Senior Advisor	Children’s Services (representing Schools)
Head of Clinical Safeguarding	North West Ambulance Service

Confidentiality

2.19 Working Together to Safeguard Children 2013 clearly sets out a requirement for the publication in full of the overview report from Serious Case Reviews:

“All reviews of cases meeting the SCR criteria should result in a report which is published and readily accessible on the LSCB’s website for a minimum of 12 months. Thereafter the report should be made available on request. This is important to support national sharing of lessons learnt and good practice in writing and publishing SCRs. From the very start of the SCR the fact that the report will be published should be taken into consideration. SCR reports should be written in such a way that publication will not be likely to harm the welfare of any children or vulnerable adults involved in the case.”²

² Working Together to Safeguard Children 2013 p71

Family involvement

2.20 Given the lengthy and significant proceedings around this case it was not originally possible for the family to contribute during the SCR, however, more recent developments have meant that the parents were informed in March 2016 that a SCR was being undertaken. MCN met with the Lead Reviewer and the LSCB Senior Manager on 4 and 24 May 2016. Her comments are reflected within this report.

2.21 FCN, as of 9 June 2016, has been unable to participate in this review.

Staff involvement

2.22 The staff who were involved with Child N were seen on one occasion for a Learning Event in November 2014 in order to:

- Clarify the information contained in the combined chronology and to allow the lead reviewer to find out about Child N's history and to develop hypotheses.
- Consider the narrative of the situation and consider possible lessons.

2.23 In parallel to the serious case review a Child Death Overview Panel process (CDOP) will be carried out into the death of Child N. The CDOP process will conclude once the final Inquest outcome has been received (and this SCR has concluded).

2.24 The SCR was unable to be concluded or published earlier as further legal proceedings in the Family Court were commenced, and these only concluded in late 2015. The Finding of Fact was published in January 2016 as identified earlier in the review report. There then followed discussions by the LSCB with the Coroner, the Crown Prosecution Service and with the Independent Police Complaints Commission who all had a part to play in this case. The LSCB is required to have due regard to the impact of any ongoing legal proceedings when compiling and publishing the report. (Working Together 2015). By April, 2016, all three had confirmed that there was no bar to the LSCB publishing the SCR, once finalised.

2.25 MCN spoke positively of the experiences she had with the Social Worker, during the early years for Child 2, her Health Visitor, Midwife and GP, all of whom had been consistent and supportive.

Dissemination of learning

2.26 The learning from this review will be disseminated to the LSCB agencies via the Learning and Improvement sub group and the Communication and Engagement sub group in order to raise awareness and improve professional practice.

Race, Religion, Language and Culture

2.27 Child N and her family were English White British. Religion is not considered to be a feature of their lives and they are described as working class.

3 BACKGROUND INFORMATION

3.1 What the Expert Leads Panel now understands about Child N and her family raises a number of practice issues, both for individual agencies and for the LSCB, particularly in relation to families with complex and/or multiple needs and risk factors.

3.2 The review attempted to identify how agencies and individual practitioners responded to the needs of Child N and her family between March 2011 and Child N's tragic death in December 2012.

3.3 In order to do this agencies carried out reviews of their records and materials including:

- Electronic records
- Paper records and files
- Patient or family held records

3.4 Although the time frame of the review covers a relatively short period of time, agencies did hold historical information about MCN and FCN which was relevant to the assessment of risk and need in this case and this is detailed below. This is relevant contextual information.

Child N and her family

3.5 The Lead Reviewer and participants in the SCR and learning event kept Child N at the centre of the review and in doing so focused on the family environment and circumstances that she was born into.

3.6 Child N was a twin and was one of 6 children living in a small 3 bedroomed house in Cumbria with her parents MCN and FCN. The eldest child was 9 years old and Child N and her twin the youngest at 13 months old.

3.7 Health visitors who attended the Learning Event and who had observed Child N in her home environment described the family household as noisy and chaotic and also described Child N as appearing to be a happy and healthy baby.

3.8 There were however several indicators that Child N's parents (MCN and FCN) parenting capacity may have been compromised. These indicators are described in more detail below.

Child N's Parents

MCN

- 3.9 MCN is the youngest of 5 children. MCN's own mother (Child N's grandmother) had been in the care system as a child and lived in a number of foster homes. MCN's father had been in care and borstal and described himself as a former 'jail bird'.
- 3.10 An initial Child Protection case conference was held in December 1992 in respect of MCN and her 4 siblings. The children were registered and a risk assessment was undertaken in May 1993.
- 3.11 The children's names were removed from the Child Protection Register in September 1993.
- 3.12 The children's names were again placed upon the Child Protection register in July 1995 due to concern about the risk to MCN from an older sibling's violent behaviour. The two oldest siblings, who were twins, spent periods of time in foster care under section 20 of the Children Act 1989.
- 3.13 MCN witnessed domestic abuse as a child and was a victim and a perpetrator of domestic abuse as a young adult.
- 3.14 There were indicators that MCN was groomed and sexually exploited by a male and female when she was around 15 years of age, at this time she was dating the couple's lodger.
- 3.15 MCN left her family home and went to live with the couple in January 2000 when she was aged 15. MCN called them 'mum' and 'dad' and changed her name using the male's surname. This was on the advice of the adult female and was with the intention of hiding her whereabouts from Children's Services.
- 3.16 MCN was made subject to Child Protection Procedures when she refused to leave the couple's home and she was pregnant at the time with her first child (Child 1). The Court granted an Emergency Protection Order in respect of MCN due to concerns about child sexual exploitation and she returned to Cumbria, to foster care on 10th May 2000.
- 3.17 MCN ran away again to be with the couple and there were concerns that this child's father may have been the adult male of the couple which MCN denied. MCN gave birth to Child 1 in October 2000. At this point, MCN was aged 16.

- 3.18 MCN and her baby (Child 1) were assessed in a mother and baby unit out of the area. The outcome of the assessment was positive and MCN returned with Child 1 to Cumbria with no follow up support. Initially MCN and Child 1 resided with one of her siblings, but due to the sibling's lifestyle (alcohol misuse), MCN and Child 1 moved into rented property.
- 3.19 In January 2002 MCN was arrested by police as she was found to be drunk in charge of Child 1 who was aged 14 months and Child 1 was consequently removed from MCN's care and adopted in January 2004. MCN was then aged 19.
- 3.20 Child 1, became the third generation to become a looked after child in MCN's family.
- 3.21 MCN's second child (Child 2) was born in 2003 when MCN was 19 years of age and care proceedings were issued. Child 2 was placed with MCN at home. The placement was successful and the care order was discharged in 2007.
- 3.22 MCN gave birth to her 3rd child in 2006. (The Care Order in respect of Child 2 was still in place) MCN's 4th and 5th children were born in 2008 and 2010.
- 3.23 FCN and MCN met in 2008 when he was 40 and she was 23. They began a relationship in 2009 and started living together in 2010.
- 3.24 MCN's 5th child was 6 weeks old when MCN became pregnant with twins, Child N and her sibling (Child 6). MCN did not access maternity care with this pregnancy until she was 21 weeks pregnant. (FCN is stated to be the father of Child 5 as well as Child 6 and Child N). MCN told the reviewer that the reason she did not access maternity care earlier was due to her own father's death. MCN was responsible for making funeral arrangements and this resulted in her missing some ante natal appointments.
- 3.25 In summary, there were elements of MCN's own childhood that had been difficult and traumatic. Her family had intergenerational experiences of neglect and abuse and frequent contacts with children's social care and other services.
- 3.26 There were indicators that MCN may have been sexually exploited by an older couple. Her reluctance to leave the couple after having run away to be with them indicates her attachment to them and is a possible indicator of her own poor parenting experiences and/or that significant emotional exploitation and coercion was taking place.

- 3.27 MCN became pregnant with Child 1 during this period when she was extremely vulnerable and she could not care for this baby eventually losing the child when the child was taken into care and subsequently adopted.
- 3.28 MCN has not received any tailored therapeutic intervention in respect of her own experiences of sexual and other abuse or the trauma of her child (Child 1) being placed in care.
- 3.29 All of these unresolved significant and traumatic life events were indicators that at the very least, MCN's parenting capacity and possibly her ability to protect herself and her children from harm could be compromised.
- 3.30 Throughout the individual agency reports and from the accounts of the practitioners participating in the learning event, there emerges a picture of MCN as a young woman with complex and multiple vulnerabilities however her superficial presentation was of a competent and coping mother of 6 young children.

FCN

- 3.31 Agencies knew less about FCN's early childhood.
- 3.32 FCN spent time living in a major city and where he was homeless. He describes this experience as 'brutal'.
- 3.33 FCN is an ex-partner of (and had a child with) the adult female with whom MCN lived when she was 'missing from care'. He has no contact with this child.
- 3.34 FCN has one other child with whom he has no contact.
- 3.35 FCN met MCN in 2008 when he was 40 and she was 23. They began a relationship in 2009 and started living together in 2010 (however this was disputed by MCN prior to publication of this report).

4 ANALYSIS AND RECOMMENDATIONS

- 4.1 This section sets out an analysis of key findings and associated recommendations that are designed to offer challenge and reflection for the LSCB and partners.
- 4.2 The key lines of enquiry for the SCR were explored through the process of the Learning Event and considered together with the details submitted in individual agency chronologies:

Did any agency recognise and assess risk in respect of Child N or any of her siblings?

- 4.3 Complexity of risk and need is not always obvious within a family. However MCN had experienced significant historical traumas and loss which were, in themselves, clear indicators that her parenting may have been compromised and that her children could be at risk.
- 4.4 MCN was made subject of a Child Protection Plan in 1992, in 1993 and again in 1995 as a result of physical and sexual abuse. She became a looked after child in May 2000 at the age of 15 when she was pregnant and at risk of sexual exploitation.
- 4.5 Factors that are known to be associated with risk to babies and very young children (Ward et al 2012) include parents who have experienced abusive childhoods themselves and have not come to terms with the abuse. Additional risk factors include domestic abuse and environmental stressors such as housing. Significant protective factors are the presence of a supportive non-partner, wider family and informal support and parent's insight understanding and capacity to change. Severe risk of harm is most likely where there is an absence of protective factors. *Ward, H., Brown, R., and Westlake, D. (2012) Safeguarding Babies and Very Young Children. London: Jessica Kingsley Publishers.*
- 4.6 Furthermore, children who have been sexually abused and exploited, as it is thought MCN may have been, are more likely than other children to be re-victimised both as adolescents and adults. They are also more likely to have been targeted by the perpetrator specifically because of their particular vulnerabilities (Conte, Wolf, & Smith, 1989, Elliot, Browne, & Kilcoyne, 1995). This increases the likelihood that MCN and by default, her children, would be vulnerable to further abuse. *Conte, J., Wolf, S., & Smith, T. (1989). What sexual offenders tell us about prevention strategies? Child Abuse and Neglect, 13(2), 293–301.*
- 4.7 Additionally, children who are emotionally or physically neglected can develop long-lasting problems. Intimacy and nurturing skills are typically underdeveloped and can lead these children to have relational problems later in life with other adults and their own children. Some children who experience neglect will form quick, over-involved and inappropriate attachments with others. This leaves them vulnerable to abuse.
- 4.8 MCN's inability to care for her first child led to that child being removed from her care. A study published by the Children's Workforce Development Council

noted that there were complex, ethically sensitive, and emotive reasons, as to why some mothers whose children were removed from their care repeatedly fell pregnant. Although contraception, and advice around this area, was seen as important, it was felt to be unlikely that this alone would effect change. Most of the social workers who took part in the study felt that the mothers with whom they were working would fall pregnant again. In one case the mother was already pregnant and due to give birth to her sixth child. The reasons suggested by the social workers as to why the mothers would get pregnant again were around 'filling the void in their lives,' or related to 'getting into a new relationship with a man.' In most of the cases, the social workers stressed that the parents often had very difficult childhoods themselves, and several parents were care leavers/young parents. *"What can professionals do to support mothers whose previous children have been removed: An exploratory study"* Emma Blazey and Emma Persson 2010.

- 4.9 There is no information that health visitors or midwives working with the family recognised or assessed the trauma of MCN's own childhood, the loss her first child into care or, given her vulnerability to further abuse, or her relationship with FCN, a man 17 years her senior, as potential sources of risk to the children.
- 4.10 There is no evidence that practitioners considered that MCN's repeat pregnancies would compromise her ability to care for her children or that the repeat pregnancies were symptomatic of unresolved loss. As indicated above, she appeared to be a competent and coping mother of six young children

Recommendations: Effective Risk Assessment

- 4.11 Using the learning from this Serious Case Review the LSCB should consider its practice approach to families with similar histories to Child N's in particular its understanding of the long term impact of unresolved childhood trauma and abuse on parenting capacity. (N1)
- 4.12 The use of family history, chronology and genealogy to identify patterns of risk should be promoted through multi-agency partnerships and used at the earliest opportunity. (N2)

What reassured practitioners that Child N was safe and well?

- 4.13 Child N was entirely dependent on the adults surrounding her to meet her needs and as she was too young to communicate verbally, the health visitors, midwives and the GP who came into contact with her relied on her outward appearance as a happy and thriving baby.

- 4.14 Because the indicators of risks and vulnerabilities in respect of MCN and FCN were not explored by the midwives, health visitors and GP, who came into contact with Child N this outward appearance was not questioned. Health Visiting practitioners who attended the learning event who had worked with the family and who knew Child N described her as appearing lively and happy. They did however express concern that her twin (Child 6) was withdrawn and looked 'sad'. There were no records available to indicate when or how often this presentation had been noted. This difference in how the twins presented was not explored further as there were no other apparent signs that any of the children were experiencing harm. (N.B. In conversation with the Lead Reviewer MCN described Child 6 as 'laid back' especially when contrasted with Child N).
- 4.15 Health Visiting Practitioners also described the family environment as noisy and chaotic which given the number of school age and pre-school age children present, was not surprising. This environment would have made professional observations of each individual child difficult and did not appear to have triggered a reflection of what Child N's lived experience would have been like or whether it was possible that MCN could meet her and her siblings entire range of needs.

Were any signs of abuse missed by practitioners?

- 4.16 There were no apparent physical signs of abuse in respect of Child N who was regularly seen by health professionals. MCN took her children (including Child N) to the family GP on a regular basis to seek help appropriately for their childhood illnesses. MCN did miss taking Child N's sibling to appointments with the audiologist but the majority of other health related appointments were attended.
- 4.17 A review of the medical histories of MCN's other children showed that MCN appropriately sought medical treatment or advice for injuries to immobile infants on several occasions.
- 4.18 None of these injuries to immobile children were suspected to be non-accidental however the injuries were treated in isolation and none of them triggered further enquiries or a Common Assessment Framework (CAF) which could have ensured that appropriate support was put in place for MCN. It is worth noting that had a CAF been considered MCN could have refused to co-operate and refused any help and support offered which in itself may have raised the level of concern.
- 4.19 MCN did not seek antenatal care for her twin pregnancy until she was 20-21 weeks pregnant. The reasons for this late presentation were not queried and not viewed as a sign that MCN may have needed support. However, in

discussions with MCN, the reason for this was the death of her own father, which resulted in some missed appointments and a delay in attending earlier.

- 4.20 Furthermore, neither MCN nor FCN sought medical attention for any incident that could have caused the fractures to Child N's leg which were only discovered at the post mortem and found then to be healing fractures. To a carer who did not know how and when the fracture occurred, the later symptoms might be non-specific and might be masked if the child had been given paracetamol for a few days after the injury as a non-specific treatment for discomfort and irritability.
- 4.21 The LSCB should consider the development of a multi-agency policy regarding injuries to immobile infants. (N3).

What can we learn from our response to Child N and her family?

- 4.22 This SCR demonstrates the critical importance of a family's complex history as an indicator of future risk and need.
- 4.23 Child N's family history included inter and multi-generational abuse.
- 4.24 This history was highly relevant to any assessment of MCN's need for therapeutic and other support as she grew through adolescence into young adulthood and became a very young parent.
- 4.25 MCN was effectively discharged from the care and supervision of the local authority after the discharge of the Care Order of Child 2 in 2007 following a judgement by the Family Court supported by statements from an independent social worker, the child's Guardian and a Consultant Clinical Psychologist all of which stated that she was able to safely parent Child 2.
- 4.26 There were no plans put in place for any long term support or intervention to ensure that MCN and her children were safe and thriving despite the fact that there were several significant indicators that her capacity to parent may have been compromised by her own childhood experiences of trauma and abuse.
- 4.27 MCN was 27 years of age when she became pregnant with twins and the youngest of her 4 children living with her was only 6 weeks of age. There is no information that any practitioner considered MCN's repeat pregnancies as what may have been a symptom of unresolved loss or considered an offer of more targeted help and support.
- 4.28 The stress and strain of caring for a very young family and a twin pregnancy ending in an emergency caesarean section were stand-alone indicators of need however there does not seem to have been a thorough assessment of MCN

and FCN's ability to cope or a targeted offer of a CAF (now referred to as 'Early Help').

Was the parenting capacity of Child N's parents effectively assessed?

- 4.29 MCN was viewed by health practitioners as resilient and as a good parent who engaged the children in lots of activities.
- 4.30 In addition, the schools attended by MCN's older children raised no concerns about the attendance, behaviour or the development of the other children.
- 4.31 However, there was no information to suggest that any practitioner reflected that MCN's history would make it difficult for her to meet all of her children's needs or that her own mental and emotional wellbeing might be affected by past trauma and loss.
- 4.32 In light of MCN's history, a comprehensive and ongoing multi-agency assessment of her parenting capacity would have been warranted on a planned basis (certainly as each pregnancy and birth occurred) and plans put in place to support her in her parenting role. These plans would ideally have reflected any therapeutic needs and also have identified that MCN and therefore her children were at higher risk of abuse because of MCN's own history.
- 4.33 The role of the male partners / fathers involved in MCN and the children's lives was not understood. Very little was known about FCN and his parenting capacity did not appear to have been considered and was never assessed.

Recommendations

- 4.34 Using the learning from this SCR, the LSCB will need to be assured that practitioners demonstrate professional curiosity and scepticism around fathers and other males who associate with high need or complex families particularly where there has been a history of sexual exploitation or abuse. (N4)
- 4.35 This approach would also need to be responsive and recognise the dynamic nature of need and risk in the context of a rapidly growing family where there have been a number of male partners/ fathers involved in the lives of MCN and her children. (N5)

How well information was shared, understood and responded to between agencies?

- 4.36 Practitioners who attended the learning event stated that they did not know all of the facts of the case and this underlines the importance of the early use of genograms and chronologies when working with families with complex histories and/ or who have involvement with several agencies.

4.37 The information that was known about MCN in particular was not well understood and therefore was not responded to especially as there were no significant incidents which would have warranted information sharing without her consent.

Supervision and Management, what do practitioners need when working with families like Child N's?

4.38 Professional thresholds and tolerance of what is regarded as 'normal' were discussed by participants at the learning event and there was an acknowledgement that there are families who share similar histories and presentations as Child N i.e. multiple births, children's social care involvement with several generations of the same family and that this is normalised in some communities and amongst some professionals.

4.39 It is important that thresholds of normality and 'good enough' parenting are the same for every family in Cumbria so that there is a consistent response to risk and need for every child and young person.

4.40 Supervision practice needs to quality assure the response to families who share Child N's family context and ensure that thresholds and tolerance are 'fixed points' shared by all practitioners.

Recommendations:

4.41 Using the learning from this SCR the LSCB should provide opportunities for frontline practitioners and their supervisors to further their understanding of need and risk in women with MCN's profile such as mothers who are care leavers, own child removed, a large number of subsequent children. (N6)

4.42 The LSCB should consider developing support to Health Visitors, social workers, midwives and Early Help practitioners ensuring that they have access to extended/enhanced supervision and multi-agency group support to discuss themes and concerns such as through the use of Core Groups. (N7)

Additional Analysis

4.43 MCN shares a similar history with some other young parents whose children historically became the subject of SCR's both in Cumbria and across the UK. Teenagers who become parents are known to experience greater educational, health, social and economic difficulties than young people who are not parents, and their children may be exposed to the consequences of greater social deprivation and disadvantage. These outcomes have been demonstrated to be more adverse still in the case of looked after children who become parents

because this group are more likely than others to be unemployed, have more mental health problems, be expected to be independent with little social or economic support.

- 4.44 Some Looked After Children (LAC) who become teenage parents may need long term support to enable them to parent safely and effectively.
- 4.45 It is recommended that the LSCB conducts a thematic review of the LAC cohort of girls with a specific focus on a) preventing teenage pregnancy and b) where girls do become pregnant developing and adapting new ways of working which would include consideration of therapeutic interventions, family fostering arrangements, and highly personalised gender specific and tailored support packages for mothers who have been looked after and/or experienced neglect, trauma and abuse. (N8).

Summary Analysis

- 4.46 MCN's history of abuse, loss and possible sexual exploitation made her and possibly her children vulnerable to further exploitation and abuse. Her relationship with any male could be a source of potential risk e.g. the age difference between MCN and FCN was significant but this did not trigger any professional curiosity despite the fact that MCN's history of possible sexual exploitation was known to some practitioners.
- 4.47 There were no physical signs that Child N was being harmed in any way. She appeared to be a bright and happy baby and there were no other obvious signs that she was at risk.
- 4.48 It is only by considering MCN's family history over the last 3 generations and understanding the impact of trauma and loss on her ability to keep herself and her children safe that we would see the need for a much more pro-active and less optimistic approach to assessing risk and need particularly around MCN's relationships with males.
- 4.49 Research consistently shows the presence of an intergenerational cycle of care involvement for some families. For example, one study found that adults who were taken into care when they were children are 66 times more likely than their peers to have their own children taken in to care (Jackson and Smith, 2005). Another study which included 20 young care leaving mothers found that two of the children of these mothers had become looked after children within 10 to 18 months of leaving care (Dixon et al, 2006).
- 4.50 A study of 63 young parents in and leaving care also suggested an intergenerational cycle of care involvement. Of these young parents, five had

had their children taken into local authority care, one was attending a child protection conference to retain custody of two children, and another had had her baby temporarily removed. A number of others had experience of their children being placed on child protection registers. (Chase et al, 2006).

- 4.51 The recommendations in this case focus on how practitioners recognised, assessed and responded to need and risk and what the implications are for supporting and supervising practitioners in their work with other families in Cumbria. The full list of recommendations is included in Appendix A.

5 CONCLUSION

- 5.1 Child N, as a baby, relied upon the adults in her life to keep her safe and meet her needs and this review has, necessarily, focused upon her parents MCN and FCN. Specifically this review explored how agencies who worked with the family recognised, understood and responded to risk and need.
- 5.2 Research evidences that women (and men) with multiple and complex vulnerabilities who have experienced childhood trauma and abuse may find it difficult to safely navigate and manage adulthood and parenthood.
- 5.3 However there is little evidence available with a specific focus on parenting as to what works over the long term (10 years plus) with women and girls who share similar histories to MCN. This is an important focus if we are to improve how we currently work with women and families who have multiple vulnerabilities with several generations of the children of some of these families coming into the care of the local authority.
- 5.4 The author of this report would like to thank the practitioners who attended the learning event who were willing to share, reflect and learn and thank the panel of Expert Leads for their contribution to this SCR. As detailed previously, MCN spoke positively of the experiences she had with the Social Worker, during Child 2's early years, her Health Visitor, Midwife and GP, all of whom had been consistent and supportive.
- 5.5 The author would also like to thank MCN who showed significant courage in coming to meet with her and the LSCB Senior Manager.

Appendix A - Recommendations

Recognising and Assessing Risk and Need

Using the learning from this SCR the LSCB should consider its practice approach to families with similar histories to Child N's in particular its understanding of the long term impact of unresolved childhood trauma and abuse on parenting capacity. (N1)

The use of family history, chronology and genealogy to identify patterns of risk should be promoted through multi-agency partnerships and used at the earliest opportunity. (N2)

The LSCB should consider the development of a policy regarding injuries to immobile infants. (N3)

Responding to Risk and Need

Using the learning from this SCR, the LSCB needs to be assured that practitioners demonstrate professional curiosity and scepticism around fathers and other males who associate with high need or complex families particularly where there has been a history of sexual exploitation or abuse. (N4)

This approach would also need to be responsive and recognise the dynamic nature of need and risk in the context of a rapidly growing family where there have been a number of male partners/ fathers involved in the lives of MCN and her children. (N5)

Support and Supervision

Using the learning from this SCR the LSCB should provide opportunities for frontline practitioners and their supervisors to further their understanding of need and risk in women with MCN's profile such as mothers who are care leavers, own child removed, a large number of subsequent children. (N6)

The LSCB should consider developing multi-agency support to Health Visitors, social workers and midwives ensuring that they have access to extended/enhanced supervision and multi-agency group support to discuss themes and concerns such as through the use of Core Groups. (N7)

Recommendation for the LSCB

It is recommended that the LSCB conducts a thematic review of the LAC cohort of girls with a specific focus on a) preventing teenage pregnancy and b) where girls do become pregnant developing and adapting new ways of working which

would include consideration of therapeutic interventions, family fostering arrangements, and highly personalised gender specific and tailored support packages for mothers who have been looked after and/or experienced neglect, trauma and abuse. (N8)

Appendix B - References

Blazey E and Persson E (2010) What can professionals do to support mothers whose previous children have been removed? An exploratory study.

Chase, E., Maxwell, C., Knight, A and Aggleton, P. (2006) Pregnancy and Parenthood Among Young People in and Leaving Care: What are the Influencing Factors, and what Makes a Difference in Providing Support? *Journal of Adolescence* 29: 3 437-451

Conte, J., Wolf, S., & Smith, T. (1989). What sexual offenders tell us about prevention strategies? *Child Abuse and Neglect*, 13(2), 293–301.

Dixon, J., Wade, J., Byford, S., Weatherly, H. and Lee, J. (2006) *Young People Leaving Care: A Study of Costs and Outcomes Report to the Department for Education and Skills*. York: University of York

Jackson, S. and Simon, A. (2005) The Costs and Benefits of Educating Children in Care in Chase, E., Simon, A., & Jackson, S. (Eds.) *In Care and After: A Positive Perspective* (pp.44–62) London: Routledge

Ward, H., Brown, R., and Westlake, D. (2012) *Safeguarding Babies and Very Young Children*. London: Jessica Kingsley Publishers.

Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children' (2013).