Vulnerability Knowledge & Practice Programme

Learning for the police from reviews of child death and significant harm: Young parent families

A fifth briefing concerning CSPRs/SCRs/CPRs produced by the VKPP.

December 2021

Dr Andrea J. Darling

Contents

Introduction

When it began operating in 2018 the Vulnerability Knowledge and Practice Programme (VKPP)[1] established a process for drawing out learning for the police from statutory reviews. This has resulted in the publication to date of a series of briefings which can be located here. The VKPP is continuing to build on this evidence base by identifying practice issues as they emerge in reviews, as well as good policing practice where possible.

This is the fifth briefing produced by the VKPP focusing on Child Safeguarding Practice Reviews (CSPRs) in England [formerly known as Serious Case Reviews; SCRs] and Child Practice Reviews (CPRs) in Wales. It is the first of a series of three briefings resulting from the analysis of 64 unique CSPRs/CPRs/ SCRs published between 30th September 2019 and 23rd July 2020 (see Appendix A for an overview of the full study methodology). This briefing focuses on police engagement and responses to young parent families. This special theme draws on cases from our larger sample of 64 case reviews.

[1]This programme operates under the auspices of the National Police Chiefs' Council Lead for Violence and Public Protection. You can read more about this programme here: https://whatworks.college.police.uk/Research/Pages/Vulnerability.aspx

Snapshot of cases

Police forces

The cases constituting the full sample involved 22 forces over 8 police regions.

Case types

34 of the cases related to the death of child or adolescent and 30 related to incidents of significant harm.

Death

Cases involving the **death** of a child/adolescent (34):

- 11 Sudden Unexpected Death in Infants (SUDI)
- 10 suicide
- 5 fatal assaults
- 2 fatal physical abuse
- 2 'overt filicide'
- 2 child homicide
- 1 other (untreated terminal illness)

Significant harm

Cases involving **significant harm**[2] to a child/adolescent (30):

- 11 Physical assault
- 8 child sexual abuse/exploitation
- 6 multiple abuse (neglect; physical; sexual)
- 3 other (2 attempt suicide; 1 abduction)
- 2 neglect

The 64 cases featured a range of contextual elements of note even where the lead reason for harm/ death is something different. These included: mental health needs (36 cases); domestic abuse (31 cases); the child or young person going 'missing' (12 cases); child sexual (10 cases); child sexual exploitation (10 cases); child criminal exploitation (7 cases) and financial exploitation (4 cases).

We use case examples in this briefing either to provide context or exemplify issues that have been identified as collective learning over a number of reviews or where the circumstances of a particular review are potentially unusual but where there is learning that could be applied in similar circumstances in the future. Reviews are likely to be the result of an accumulation of complex systemic and multi-agency factors.

[2]The death and harm types here are assigned from the main issue associated with the death or serious harm and the lead reason for the review being conducted. Other harms and circumstances may also have been present in the case.

Special Theme: YOUNG PARENT FAMILIES

Key Factors

Parents/carers of children at risk can be adolescents themselves. These circumstances can create a very complex situation that police may need further professional help to resolve. While the initial focus may be on the young adult as a parent, their needs as vulnerable young people are crucial in considering the wider risk for the family.

Many young parents have suffered adverse childhood experiences themselves and some continue to live challenging lives. Comprehensive risk assessment is vital in these circumstances and this needs to be driven by: professional curiosity; diverse sources of information; careful investigation of the current situation and assessment of presenting behaviours. It is very important for police to look for the clues and indicators of potential risk as the young parents may not be forthcoming about the reality of their situation.

Special Theme: YOUNG PARENT FAMILIES

Several cases identified in our analysis concerned the death or serious harm, including non-accidental injury, of the children of adolescent parents, who had their own vulnerabilities and health and welfare needs. There were also examples of young partners of a child's mother (not birth fathers) being involved with the family where they also had significant difficulties or need. A national Child Safeguarding Practice Review Panel's previous annual report also notes how perpetrators of non-accidental injury to babies under a year old were often very young parents with minimal social support.

Although much of the agency support for young families in the current set of reviews was provided by health and children's service practitioners, police were generally involved in wider safeguarding arrangements or in responding to domestic abuse, missing young people or potential child sexual exploitation (CSE) of the child parent, prior to the specific incident which led to each individual review being required. Some of these young parents had other experiences of trauma or adverse childhood experiences, for example through their own experiences of neglect or child sexual abuse, living in care, mental health difficulties or substance and alcohol misuse.

Previous reports detailing safeguarding review findings have identified the importance of recognising the relationship between adolescents' prior experiences and their risk of harm. Our third serious case review briefing identified this issue noting that improved risk assessment requires awareness of the range of vulnerabilities present for young parents and that while the focus may be on the young adult as a parent, their needs as vulnerable young people are crucial in considering the wider risk for the family.

Parents' or carers' own childhood adversity or behaviour during adolescence may lead to social isolation, stress and difficulties in engagement with services (Brandon et al., 2020).

Similar findings are reflected in the latest triennial review of serious cases with the most prevalent parental characteristic reported (for parents of all ages) being mental health need, particularly in the mother but also in the father or father figure. In turn this can mean young parents may find professional meetings difficult, may feel like they do not have a voice, that they are being judged and they may find it difficult to understand language used and the detail of child protection processes. This can mean that it may be difficult for them to remember or achieve agreed plans/actions, leave them feeing out of control.

Special Theme: YOUNG PARENT FAMILIES

Young parents and their children may have overlapping but different challenges and needs. It's important to recognise that providing support to young parents and partners does not necessarily mean that the child is also being supported or protected (NSPCC, 2021).

Given the combined complex needs of both parents/carers and children in some cases, there were times in the cases analysed for this current briefing when either the needs of the child/children or the parent(s)/carer(s) appeared to dominate the considerations of police and other agencies involved with the family, leaving some of the needs of the other parties unrecognised or unmet. In responding to incidents involving young parent families police need to take care to risk assess the situation widely, considering the needs of all involved, not just the child/parent who may be the subject of the original requirement to respond. Following this broader risk assessment, if specific needs are identified, officers also need to make appropriate referrals to ensure all parties have adequate support where necessary.

How best to balance the needs of the child with those of parents is a recognisable challenge for all those working with children and families. This scenario could be addressed by social care assessments considering the reasons why a young parent or carer may present a risk and what support is available for them in their extended family or wider community, as well as identifying the risks to the child. Additionally, where appropriate, ensuring that children and young people who are parents themselves are also subject to their own support from social care would assist. Police can ensure that children and young people, who they identify are at risk themselves, are referred into multi-agency arrangements to ensure a section 47 investigation and joint child protection plan can be considered. By incorporating a broader consideration of the risks and sources of information discussed above police can make better informed referrals into local authorities and other sources of support.

The cases analysed for this briefing also highlight some of the challenges and issues concerning transitional safeguarding arrangements for young people who were also young parents/carers from children's to adult services. Adolescents and young adults can experience a range of risks and harms which may require a distinctive safeguarding response and special consideration, for example: mental health problems; homelessness; risks of exploitation; family conflict; loneliness and social isolation; poverty and drug and alcohol misuse.

Special Theme: YOUNG PARENT FAMILIES

In addition to reviews undertaken when parents and carers were still adolescents themselves, there were also several cases involving neglect and harm of children where their parents and carers were in their early 20s at the time of the review. These parents were struggling to cope having had a number of children over a period of only a few years during their own adolescence and young adulthood. Much of the learning and potential practice related to adolescent parents would apply to these families too.

Although issues involving families with young parents and carers have been identified in previous reviews and reports, a previous biennial review noted that the needs of young teenage parents and the challenges that they may face rarely lead to any specific recommendations in published serious case reviews. We also found this to be the case, both more generally and in relation to specific recommendations for the police in responding to young parent families. A number of issues were identified relating to police responses, some of which are discussed above. Across the cases analysed there were examples of ineffective risk assessment by the police of the risk and previous history of fathers or other partners involved in young parent families (including when the child is not yet born) and missed opportunities to fully consider the impact of adverse childhood experiences of young parents/partners upon their ability to safely care for the child. This recent briefing from the NSPCC (2021) also identifies the same issues and missed opportunities concerning practitioner responses to young parent families discussed above.

We provide two case examples from our analysis which demonstrate some of the findings referred to above. The examples also reflect some of the trauma and risk indicators and ongoing vulnerabilities of young parents which can impact of their ability to protect or safely care for their child(ren) and which need to be taken into account in any risk assessment and management by the police.

Special Theme: YOUNG PARENT FAMILIES

Case Studies

The first case involves an adolescent mother previously believed to be a victim of child sexual exploitation by the adult father of her child. They remained in what she defined to be a 'relationship'. The child had complex medical needs, was at risk of medical neglect and the young mother continued to experience domestic violence from the child's father.

The mother called the police out to a domestic incident involving the adult male at her home when she was pregnant and he had been drinking alcohol. The male had left the home prior to officers attending. A DASH was completed and a referral correctly sent to the MASH but the mother declined offers of further support. The mother was advised to consider Clare's Law but the reviewer found no evidence of this ever happening. The reviewer could find no evidence that the police spoke directly to the adult male after this incident and they did not appear to consider the risk to the unborn baby.

Clare's Law, the Domestic Violence Disclosure Scheme (DVDS)

The DVDS gives members of the public a formal mechanism to make enquiries about an individual who they are in a relationship with, or who is in a relationship with someone they know, where there is a concern that the individual may be violent towards their partner.

The police were also party to information and concerns about the mother being a previous victim of CSE involving the adult male. The reviewer found that this information should have been considered by the police and shared with other agencies during pre-birth assessments. Had that been done, professionals would have had reason to consider the power balance in the mother and adult male's ongoing association and any associated risks posed to the baby as a result.

After the child was born police were also aware of concerns raised at a strategy meeting regarding the child not being brought to vital health appointments. After a decision was made at a multi-agency strategy meeting to escalate the case to an initial child protection conference, police did not follow up when arrangements for the conference to take place did not materialise. Assumptions had been made by police that children's social care would take the lead stance on such cases. This highlights the importance of a shared understanding of responsibility between police and other multi-agency partners and that police colleagues need to escalate issues when agreed actions in cases do not appear to have been taken. This issue has been repeatedly identified in other VKPP publications and is also the focus of NVAP Action 2.2.1 'Appropriate Action'.

Special Theme: YOUNG PARENT FAMILIES

Case Studies

NVAP Action 2.2.1

NVAP 2.2.1 Appropriate Action: In response to identified risk, ensure staff understand and utilise appropriate referral pathways including how to access partner provisions and are empowered to challenge or escalate decisions.

The review also identified several wider findings applying to all agencies including the police which have also been highlighted in other reviews and briefings (as discussed above). These included: a lack of professional curiosity about fathers; a lack of professional challenge between practitioners and agencies and a lack of focus on the child. Recommendations were made concerning ongoing consideration as to how professionals engage with biological fathers and other male partners involved with young families. In assessing and managing risk around child protection police need to also consider the effect of significant events in a parent's own life when assessing their ability to parent their own children. The same would also apply to assessments of partners of parents who may have care for the child or have regular contact with them.

Special Theme: YOUNG PARENT FAMILIES

Case Studies

The second example case involves another young mother with a wide range of extensive needs who was not sufficiently supported by a range of agencies. This case particularly emphasises the need for police to consider carefully the most appropriate response to children and young people reportedly suffering serious mental distress. It also highlights the extent of difficulties young parents can experience as a result of their own previous experiences and the challenging circumstances they can face in trying to care for their own child in the face of adversity and vulnerability.

The review in this case was conducted to examine the serious harm experienced by a 17-year-old young mother herself, rather than her child. The mother had been known to services for several years and lived in a home with family where she was exposed to domestic abuse. She had been the victim of a sexual assault when still at school and was believed to be at risk of sexual exploitation throughout her adolescence, including after her child had been born. The young person had experienced periods of homelessness and had serious mental health needs, an eating disorder and had tried to take her own life. She had been detained and treated in mental health facilities. After the birth of her child she was in a relationship with another young person with mental health needs and who was emotionally abusive towards her.

The young person and her child were placed in a specialist young mothers' refuge after her child was made the subject of a child protection plan. When later interviewed, the refuge managers said they recognised the young person required a level of care and support that they were unable to provide and she would have been better placed in a mother and baby unit or specialist foster placement. They recognised her physical and emotional exhaustion and how she was desperate to leave her young child at times as she was overwhelmed and needed her own space.

The social worker agreed for the young person and her child to spend some nights each week at her partner's home. Although he was abusive and controlling she felt unable to cope on her own and needed someone's help in caring for her child.

The police had been involved with the young person over the several year period of the review, both as party to multi-agency safeguarding arrangements and as a result of responding to specific incidents. These included allegations of sexual assault and sexual exploitation; domestic incidents at the homes of family members where the young person and her child were present; a missing episode and safety and welfare concerns around the young person's mental health needs. The police appear to have investigated and responded to most incidents appropriately, making suitable

Special Theme: YOUNG PARENT FAMILIES

Case Studies

referrals to other agencies and to support services. However, in responding to one allegation by the young mother, of sexual exploitation by a relative of her partner, the initial police decision not to proceed (as text messages were believed to undermine the case) was subsequently reviewed and a CPS decision was still awaited at the time the CSPR was concluded. Furthermore, there were issues identified regarding the police response to a missing episode where there were significant concerns for young person's welfare after she returned home to her mother's house. Police and children's social care had differing views on how to respond when the young person's mother felt unable to control the situation at home as the young person was then threatening to self-harm. The police responder was of the view that the young person's presentation was behavioural, she would be likely be sent home if taken to hospital and advised her mother to ring the children's social care out of hours for support. Following discussions and further information sharing with the social worker, the police took the young person to a hospital under section 136 of the Mental Health Act 1983 and she was later detained for her own safety.

The case indicates the need for police to consider carefully the most appropriate response to children and young people reportedly suffering serious mental distress and threatening to self-harm. It is important to ensure no assumptions are made about their presentation or reported presentation and adopt a multi-agency approach as per Working Together 2018 in order to reach the most appropriate course of action for that child or young person.

The Mental Capacity Act (2005) is 'little under-stood across policing in the United Kingdom and few patrol officers have received any training in its application' (Quote of reviewer)

Learning and recommendations for the Police

KEY CONSIDERATIONS FOR PRACTICE FOR THE POLICE IN THEIR CONTACT WITH YOUNG PARENT FAMILIES:

Key learning point

In assessing risk and needs in families with young parents and carers (e.g. DASH assessments and multi-agency risk assessments) explore the range of vulnerabilities present for both young parents/ carers and their children. While the focus may be on the young adult as a parent in some cases, their needs as vulnerable young people are also relevant in considering the wider risk for the family.

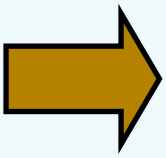
Key learning point

Where there have been concerns (but no conviction) of previous sexual exploitation victimisation against a child's mother involving the father of the child (or any other adult partner) take care to consider the potential impact upon the ongoing relationship and any consequent risk to the child. For example, think about how the parent as a potential victim of exploitation might not recognise their own victimisation or be fearful of speaking to police. Also think about their ability to be able to protect the child from any harm by the person potentially responsible for the exploitation. Consider the best way to try and engage with and support the young parent in the same way as when dealing with other victims of exploitation. In cases where the father is a known convicted offender this would be managed through existing multi-agency safeguarding arrangements.

Key learning point

There are identified risks for children and adolescents in the transitional phase between child and adult services. Police leaders, as constituent partners of Local Safeguarding Children Partnerships (LSCP), can help consider how their local plans are prioritising and assessing progress in relation to improvements required to meet the needs of children and young people in this period; both those who will move into adult services and those who may no longer receive statutory services.

Next steps



Two further briefings based on this latest sample of CSPR/SCR/CPRs are also being published on the internal police Knowledge Hub and the College of Policing Vulnerability and Violent Crime webpage, here. These will cover specific learning for police from these reviews regarding the identification and management of risk and collaborative working.

We also encourage feedback about the briefing from forces about both content and style. Please click **here** to complete a brief survey where you can provide your feedback, or, if you would like to be in touch, please e-mail vkpp@norfolk.pnn.police.uk. We'd love to hear from you.

References

Allnock, D., Dawson, J. and Rawden, H. (2020) *The role of police in responding to child and adult vulnerability: A meta-analysis of 126 reviews of death and serious harm.* https://whatworks.college.police.uk/Research/Documents/VKPP_police_response_MetaAnalysis.pdf

Brandon et al. (2020) *Complexity and challenge: a triennial analysis of SCRs 2014-2017.* Department for Education. https://seriouscasereviews.rip.org.uk/wp-content/uploads/TRIENNIAL_SCR_REPORT_2014_to_2017.pdf

Brandon et al. (2012) *New learning from serious case reviews: a two year report for 2009-2011.* Department for Education. https://seriouscasereviews.rip.org.uk/wp-content/uploads/A-biennial-analysis-of-SCRs-2009-2011-1.pdf

Holmes D & Smale E. (2018) *Transitional safeguarding - adolescence to adulthood: Strategic Briefing (2018).* Dartington: Research in Practice https://www.researchinpractice.org.uk/all/publications/2018/august/transitional-safeguarding-adolescence-to-adulthood-strategic-briefing-2018/

NSPCC (2021) *Young parents: learning from case reviews* Young parents: learning from case reviews | NSPCC Learning

The Child Safeguarding Practice Review Panel (2020) *Annual Report 2018-2019.* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/870033/Child_Safeguarding_Practice_Review_Panel___Annual_Report_2018_2019.pdf

VKPP (2019) *Learning for the police from reviews of death or serious harm or injury as a result of child abuse or neglect: Quarter 3 briefing.* https://whatworks.college.police.uk/Research/Documents/Serious_case_review_third_briefing.pdf

Appendix A:

Overview of methodology

Identifying Child Safeguarding Practice Reviews, Child Practice Reviews and Serious Case Reviews for inclusion

The NSPCC repository was searched for any new CSPRs/CPRs/SCRs added between September 2019 and July 2020 (any published in the repository before this time would have been included in the previous briefing). 41 reviews were identified by this method.

An additional search of local safeguarding children boards (LSCBs)/child safeguarding partnership (SCPs) websites for any CSPRs/CPRs/SCRs fitting the inclusion criteria as detailed below yielded a number of reviews not yet on the repository. 118 reviews were identified by this method.

Inclusion criteria

Cases were included where they fit the following criteria:

1. The incident that triggered the CSPR/CPR/SCR occurred on or after January 1st, 2016.
2. Police were involved with the child or family in the timeline of the review; if police were only involved post-incident, but learning for police practice was identified during the investigation, this was also included.
3. There is explicit reference to police practice within the review; this could be either omissions in practice or good practice identified.

Reviews were excluded from this analysis where:

1. The incident that triggered the CSPR/CPR/SCR occurred prior to January 1st 2016.
2. Police were not involved in the case at all.
3. Police were only involved in investigation after the incident, and no detail about police practice within the investigation was identified.
4. No learning was identified by the reviewer in relation to police practice.

Limitations of reviews

The reviews examined do not always go into great detail about the policing role in these types of cases. It may be possible to know, for example, that risk assessments were not of the quality expected, but it is not always possible to know why. Future reviews of this sort would benefit from reviewer's attention to the reasons *why* police practice did not meet expected standards. This would assist in increasing the relevance of learning from these reviews for the Police. Some of the themes highlighted in this briefing were not routinely identified by the reviewers but were identified from within the reviews as common themes of interest to police learning by the briefing reviewer. Readers may be interested in a news article written by a member of the VKPP team about our experiences in analyzing reviews for police practice. You can access it here.

Appendix B:

Overview of cases

Case review title and link	Review focus
Anonymous: Tracy	Death of a child under one (SUDI)[1]
Anonymous; Case W	Significant harm of a large group of siblings, abuse and neglect.
Anonymous, Child A19	Death of a teenage girl, suicide.
Anonymous; Child Z	Significant harm to an adolescent girl with complex needs
Anonymous; Family D	Significant harm to a sibling group, sexual abuse.
Anonymous; Georgia	Significant harm to a 15-year old female, self-harm.
Anonymous; Harry	Significant harm to a young male, under 16-years old, attempted suicide.
Bury; Dina	Death of a 16-year old female, suicide.
Bury; Isabella	Death of a 14-month old baby girl, (SUDI).
Cambridgeshire and Peterborough; Eleanor	Significant harm to a 19-month old baby girl, assault.
Cambridgeshire and Peterborough; Jack	Significant harm to a 3-month old baby boy.
Cambridgeshire and Peterborough; Sonia	Significant harm to a 13-year old female.
Camden; Child D	Death of a 2.5-year old child.
Cheshire West and Chester; Lauren	Death of a 16-year old female, suicide.
Cornwall and Isles of Scilly; Child C	Death of a 16-year old female, suicide.
Coventry; 2020	Significant harm (extra-familial CSA) to several children in a family
Cumbria; George	Significant harm to a 2-year old boy.
Devon; Baby F CN18	Significant harm to a 12-week old baby.
Dudley; Child A	Significant harm to a 10-week old child, non-accidental injuries.
Dudley; Young Person F	Death of a 17-year old male, stabbing.
Essex; Baby M	Death of a 3.5-month old baby, filicide.

Appendix B:

Gloucestershire; Children of Family Y	Significant harm to sibling group, male.
Gloucestershire; Children of Family Y	Significant harm to sibling group, male.
Gloucestershire; Children of Family Y	Significant harm to sibling group, male.
Gloucestershire; Children of Family Y	Significant harm to sibling group, female.
Gloucestershire; Liam	Death of a 1-month old baby boy (SUDI).
Hertfordshire; Child K	Death of a 16-year old male, suicide.
Hounslow; Sasha	Death of a 17-year old female, suicide.
Kent; Child I Carys	Death of a 16-year old female, suicide.
Kent; Child N	Death of a 9-year old male, filicide.
Kirklees; Child D	Significant harm of a 22-month old male, assault.
Kirklees; Child E	Death of a 4-month old baby boy (SUDI).
Knowsley; Child Y	Death of a 17-year old male, suicide.
Knowsley; Jane	Significant harm to a 4-year old female.
Lewisham & Harrow; Child LH	Significant harm to a 4-year old male.
Manchester; Child U1	Death of a 22-month old child, physical abuse.
Medway; George	Death of a 3-year old child, fatal assault.
Milton Keynes; Child J	Death of a 5-month old baby boy (SUDI).
Newham; Child L	Significant harm to an 8-year old female.
Norfolk; Child V	Death of a 6-month old baby girl, physical abuse.
North Yorkshire; Child C	Death of a 2-month old baby (SUDI).
Nottingham City; Young Person N	Significant harm to a 17-year old male, assault.
Oldham; Child M	Significant harm to a 15-year old male.
Rochdale Borough; Case M	Death of a 9-month old child, non-accidental injuries.
Rochdale Borough; Child X1 and Child X2	Significant harm to two siblings.
Rochdale Borough; Child X1 and Child X2	Significant harm to two siblings.
Salford; Baby MD	Death of a 5-week old baby, maltreatment.
Salford; Child T	Significant harm to a 2-year old female child, parental abduction.
Sandwell; Child HS	Significant harm to a child under one, non-accidental injuries.

Appendix B:

Sefton; Beatrice	Significant harm to an 8-week old baby girl.
Sefton; Mathilda	Significant harm to a female child under 1-year old.
Sheffield; Archie	Death of a 15-year old male, stabbing.
Southampton; Adam and Anna	Significant harm to two siblings (intra-familial CSA)
Southampton; Billy	Death of a 4-month old baby boy
Surrey; Baby LL	Death of a 4-month old baby boy (SUDI).
Surrey; Child D	Significant harm to a 16-year old female, sexual abuse.
Sutton; Child T	Death of a 17-year old, suicide.
Tameside; Child V	Significant non-accidental harm to a 7-week old child, shaking.
Torbay; C66	Death of 17-year old male, suicide
Trafford; Baby X	Death of a 4-month old baby boy, shaking.
Waltham Forest; Child C	Death of a 14-year old male, stabbing.
Waltham Forest; Child D	Death of a 4-month old baby boy (SUDI).
Waltham Forest; Kesandu	Significant harm to a 9-year old female, neglect.
Warwickshire; Child K	Significant harm to a 12-week old female child, skull fracture.
Wiltshire; Child K	Death of a 1-year old child.
Wirral; Liam	Significant harm to a 20-month old male.
Wolverhampton; Child N	Death of a 14-year old female, homicide.
Worcestershire; Isaac	Death of a 12-week old baby boy (SUDI).