7 minute briefing

Lewisham Safeguarding Children Partnership

Child FA Background

In February 2021, lockdown. After several days of being unwell, her father contacted 111. He reported that FA had presented with symptoms for a couple of days, a cold on her chest, diarrhoea, not drinking much, difficulty keeping down fluids, and a sore throat. Mr A said FA was unable to move on her own and hadn't been eating. Her breathing was heavy but had settled. Child FA then became unresponsive during the call with no pulse and an ambulance was called for. She was taken to hospital where she briefly stabilised before being pronounced deceased the same day. She was 8 years when she died.

Child Experience of Domestic Abuse

Domestic abuse features in 9.7% of child deaths, even if not a direct causal factor and 42.6% of cases of serious harm.

The lack of attention on the impact of domestic abuse on children has been highlighted by the Ministry of Justice report into Private Law cases.

The National Panel for Child Safeguarding Practice Reviews (2021) that there were insufficient links between MARACs and child in need planning, due to assessments being too adult focused

Further reading: The Child Safeguarding Practice Review Panel (2021) *Annual Report 2020.* Child Safeguarding Practice Review Panel

Quality of Working Together

There was evidence of limited working together by professionals involved with the family. Each element of the wider family being considered within a silo. Where there were referrals across the system, these were not effectively investigated. When contacts were closed, there was no challenge or escalation by those professionals who made the referrals.

The Effectiveness of Relationships between Child Focused professionals & Parents/Carers

Many parents will avoid professional intrusion into their lives. The reasons can be complex. Some might have had poor experiences in their childhood which leads to mistrust of professionals; some might feel that they might be judged; others will want to be in control of their own, and their children's lives.

This case demonstrated that those professionals who were able to give father time to process what was being asked of him, gained more access to the family and were, to some extent, listened to by him.

Impact of Covid-19- Health Care and Schools

This case demonstrates the challenge for individuals in accessing health care during lockdown periods of the Covid-19 pandemic. This has been highlighted in other Child Safeguarding Practice Reviews and the National Panel (2020) identified four aspects of risk for children during the pandemic:

1. An increase in parent and family stressors
2. Exacerbated vulnerabilities for children and young people
3. Impact of school closure
4. Impact of adaptations for Covid-Safe practice

Cultural Assumptions and Disproportionality

There was variability in how agencies practised in terms of gender, culture, and disability. This should be considered by the LSCP across a wider breadth of cases to explore the extent of the divergence of practice across the professional network. The National Panel (2021) highlights how a lack of cultural competence in the workforce can result in misunderstandings within the assessments of families and poor decision-making by practitioners. Further reading: The Child Safeguarding Practice Review Panel (2021) *Annual Report 2020.*

Child Protection in Complex Families across Households

There can be disconnect in how child protection cases are managed. For one sibling to be placed on a CP Plan without consideration of other children within the family, narrows the ability of the professional network to genuinely see the strengths and risks within the case.