DONCASTER SAFEGUARDING CHILDREN PARTNERSHIP

CHILD SAFEGUARDING PRACTICE REVIEW
Cameron

September 2022

Doncaster Safeguarding Children Partnership

Local Child Safeguarding Practice Review – 'Cameron'

1.1 Doncaster Safeguarding Children Partnership decided to conduct a local child safeguarding practice review (CSPR) following the death of a baby in 2020. The baby died after being attacked in the family home by a dog owned by the baby's father. The baby will be referred to by the pseudonym 'Cameron' in this report.

1.2 The purpose of a CSPR is to identify improvements to be made to safeguard and promote the welfare of children. It is expected that CSPRs will be published in order to widely disseminate learning from the review. However, the Safeguarding Children Partnership must ensure that reports are written in such a way so that what is published avoids harming the welfare of any children or vulnerable adults involved. Doncaster Safeguarding Children Partnership has taken account of the circumstances of Cameron's death and consequent impact on the baby's family in deciding to publish:

- the findings of the review in brief,
- together with recommendations for improvements,
- and progress made in addressing the recommendations.

1.3 Doncaster Safeguarding Children Partnership commissioned David Mellor to be the independent reviewer for this child safeguarding practice review. He is a retired chief officer of police with ten years' experience of conducting statutory reviews. He has no connection to services in Doncaster.

1.4 The Coroner decided not to conduct an inquest.

1.5 Doncaster Safeguarding Children Partnership wishes to express sincere condolences to the family of Cameron following their tragic loss. The Partnership also wishes to acknowledge the impact of the circumstances of the death of Cameron on the professionals who responded to the incident in which the baby died and were involved in supporting the family thereafter.

2.0 Findings, recommendations and progress achieved to date

Parental Neglect

2.1 Concerns about parental neglect of Cameron's older siblings led to the family being supported by child protection[1] planning and subsequently through a child in

[1] This refers to the activity that is undertaken to protect specific children who are suffering, or are likely to suffer, significant harm.

need plan[2]. Whilst there was a strong professional focus on supporting the parents in managing to maintain 'good enough' home conditions as a key success/failure indicator, this was a narrower approach than envisaged by Doncaster's Neglect toolkit which encourages professionals to take a broader, strength-based approach to the quality of care children are receiving including physical care, safety, emotional care and developmental care.

Recommendation 1

That Doncaster Safeguarding Children Partnership uses the learning from this CSPR to inform their monitoring of progress against the strategic priority of Neglect and the associated workstreams.

Progress achieved

2.2 Doncaster Safeguarding Children Partnership has identified neglect as a strategic priority and established several work streams including implementation of the Graded Care Profile 2[3], the strengthening of training across the multi-agency partnership and conducting a multi-agency case file audit to determine the extent to which the Neglect Toolkit was being utilised.

Analysing Risk

2.3 'Signs of Safety'[4] guidance asks professionals to try and limit themselves to just three 'Danger Statements' – statements which relate to each issue where professionals are worried about what could happen if nothing changes. The CSPR observed that this could lead to risks not included in the three 'Danger Statements' receiving insufficient attention. In this case, concern about Cameron's father's dog was one of four issues which professionals were worried about. Of these four issues, the concern about father's dog was the only one which was not translated into a 'Danger Statement'.

[2] A child in need is defined under the Children Act 1989 as a child who is unlikely to achieve or maintain a reasonable level of health or development, or whose health and development is likely to be significantly or further impaired, without the provision of services; or a child who is disabled

[3] The 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.

[4] Signs of Safety (SoS) is a framework for child protection practice. SoS aims to stabilise and strengthen families through working in collaboration to identify and harness their strengths and resources. This places relationships between social workers and parents at the centre of child protection.

Recommendation 2

That Doncaster Safeguarding Children Partnership seeks assurance that the 'Signs of Safety' approach ensures that all risks to a child receive appropriate attention and that the cumulative impact of multiple risks is not obscured by a requirement to focus only on a small number of risks.

Progress achieved

2.4 'Signs of Safety' documentation has been reviewed to ensure that there are no restrictions to interventions or the identification of risks. Further training and development is also being provided to ensure that thresholds and management of risk are well understood.

Parental mental health

2.5 Professional concerns about Cameron's family were at a lower level than for many of the families practitioners were working with at that time. Whilst mother's low mood was recognised as an issue it had begun to be perceived as 'historic' and there appeared to be little attention paid to father's mental health.

Recommendation 3

When the learning from this CSPR is disseminated, that Doncaster Safeguarding Children Partnership highlights the importance of fully considering both maternal and paternal mental health and their potential impact on parenting capacity when conducting assessments.

Progress

2.6 The Safeguarding Children Partnership intend to highlight the importance of this issue when the CSPR report is published.

Responding to indications of domestic abuse

2.7 There was a missed opportunity for a DASH[5] risk assessment to be completed following of an incident of domestic abuse by the father and the opportunity to

[5] The DASH (Domestic Abuse, Stalking, Harassment and Honour based violence) is a risk assessment too for both police and non-police agencies when identifying and assessing victims of domestic abuse.

explore a subsequent incident of domestic abuse was overlooked. Possible indications of controlling behaviour by the father did not receive sufficient attention.

Recommendation 4

It is therefore recommended that Doncaster Safeguarding Children Partnership shares this CSPR with the Safer Stronger Doncaster Partnership so that the latter Partnership can consider how to make use of the learning from the case to inform Doncaster's domestic abuse training programme.

2.8 One incident of domestic abuse was reported by both parents to different agencies. The accounts provided by the parents differed markedly. There does not appear to be a system for noting that separate records of the same incidents of domestic abuse have been created.

Recommendation 5

That Doncaster Safeguarding Children Partnership shares the concerns about the system for combining reports of the same domestic violence incident reported to different agencies by the victim and perpetrator with the Safer Doncaster Partnership so that the latter Partnership can consider what action to take.

Progress (Recommendations 4 and 5)

2.9 When published, the CSPR report will be shared with the Safer Stronger Doncaster Partnership, which is responsible for working to reduce crime and disorder – including domestic abuse.

Assessing the risks which dogs may present to children

2.10 Professionals primarily perceived the family dogs to be a risk to the health and hygiene of the family. Although the child and family pre-birth assessment conducted in respect of the unborn Cameron noted that the dog which subsequently attacked the child was 'large, boisterous and not house trained' and would need to be 'kept away from the baby at all times', the concern about the dog was not included in subsequent meetings or planning.

2.11 Doncaster Safeguarding Children Partnership has comprehensive 'Dangerous Dogs Practice Guidance' which includes a risk assessment template for assessing dogs which may pose a risk to children which should be used to assist assessment of potential risk of any dog that may come into contact with a child. This risk assessment was not completed in this case and professional awareness of the guidance appeared to be insufficient. Had the risk assessment been completed, it

would have provided greater insight into canine safety issues and have drawn attention to the welfare of the family dogs who were not being well cared for.

Recommendation 6

That Doncaster Safeguarding Children Partnership promotes professional awareness of the Partnership's 'Dangerous Dogs Practice Guidance'. The learning from this case, though very distressing, should be widely disseminated to reinforce awareness of the 'Dangerous Dogs Practice Guidance'.

Recommendation 7

That Doncaster Safeguarding Children Partnership consider strengthening their 'Dangerous Dogs Practice Guidance' in the light of the learning from this case, in particular the criteria for deciding whether to make a referral to children's social care could be expanded to include injuries to children who are subject to child protection or child in need planning who are injured by a dog.

Progress (Recommendations 6 & 7)

2.12 The 'Dangerous Dogs Practice Guidance' has been revised and promoted widely to professionals. Training is being developed to support the full implementation of the guidance.

Recommendation 8

That Doncaster Safeguarding Children Partnership introduces the mandatory use of the Partnership's 'Assessing dogs who may pose a risk to children' alongside all pre-birth assessments completed by children's social care where there is a dog or dogs in the family home.

Progress

2.13 The use of the 'Assessing dogs who may pose a risk to children' is being completed alongside pre-birth assessments when considered necessary as a result of professional judgement.

GP practice response to earlier dog bite

2.14 The subsequent police investigation found that one of Cameron's siblings had previously been bitten by the dog which subsequently attacked the baby. The sibling was seen by the family GP at the time of the earlier dog bite, but the family falsely informed the GP that a stray dog was responsible. Whilst the GP practice did not feel that they should have informed children's social care about this earlier dog bite, the GP practice had not recorded the family's involvement with children's social at that time sufficiently precisely.

Recommendation 9

That Doncaster Safeguarding Children Partnership seeks assurance from the Doncaster Place Team of South Yorkshire Integrated Care Board that all GP practices accurately code any involvement that children's social care has with every child who is a patient in the practice.

Progress

2.15 Doncaster Safeguarding Children Partnership is working with the Doncaster Place Team of South Yorkshire Integrated Care Board to gain assurance that GP practices accurately code involvement of children with children's social care.

GP practice involvement in child protection planning

2.16 Cameron's family's GP practice did not attend key multi-agency meetings to discuss the family. The family were well known to their GP practice, which could have made a valuable contribution to multi-agency discussions.

Recommendation 10

That Doncaster Safeguarding Children Partnership consults with the Doncaster Place Team of South Yorkshire Integrated Care Board in order to further consider how GP practices could make a more substantial contribution to the child protection planning process.

Progress

2.17 The Doncaster Place Team at South Yorkshire Integrated Care Board is striving to enhance the involvement of GP practices in child protection conferences through close monitoring of attendance and training for GPs at which the importance of attending or providing a report to child protection conferences has been strongly emphasised.

The impact of Covid-19 restrictions

2.18 The first Covid-19 lockdown was introduced during the mother's pregnancy with Cameron. This affected contact with the family for a time, largely restricting such contact to letters, telephone calls and home visits where conversations took place on the door step or through the window. However, the family's social worker managed to complete visits during which she accessed the family home.

Good practice

2.19 The CSPR found much good practice including the positive relationship the school attended by Cameron's elder siblings developed with their mother despite needing to challenge her care of the children on occasions. Additionally, the family's

social worker supported the mother and father to achieve improvements in their care of the children and in home conditions. There was also much effective partnership working and information sharing between the family's social worker, health visitor and the children's school.