The Toxic Trio

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Wisdom is the right use of knowledge. To know is not to be wise… There is no fool so great a fool as a knowing fool. But to know how to use knowledge is to have wisdom."

Charles Spurgeon


Ditte Bandini

But what of the grey world….

- Discuss

What are the key concerns in your practice when working with families where there is any of or combination of

domestic violence ?

alcohol/ drug dependency?

mental health vulnerability?

Kieran Barley died before his second birthday

Kieron's Life

Final Overview Report BSCB (2016)

Brief chronology

- **July 2009** Children's Social Care contact- domestic abuse
- **August 2009** born prematurely 33 weeks. significant periods of separation during early weeks and health refer to poor bonding
- **September 2009** Referral to CSC from police re Kieron's father-sexual offences against children. No action as they had separated
- Move to maternal grandmas home two others adults resident there were known to have significant personal problems of their own
- **September - December 2009** regular health contact- no concerns . Noted Ms Barley ended relationship with a 53 year old man who was described as controlling and had begun a new one.
- **October 2009** Nurse Practitioner Epilepsy wrote to GP: mum reported :panic attacks; low moods; actively suicidal not bonded with the baby; she needed prompting to feed the baby at nights; Kieron was sleeping poorly, not eating and crying persistently; re-started on anti-depressants; referred to a Mother and Baby Unit
- Seen by GP she said had bonded and coping well with the help of Maternal Grandmother restarted anti depressants

- **April 2009** GP- mum reports low mood ,thoughts of an overdose but was supported by her mum and needs of baby. anti-depressants prescribed and referred to a local Mother and Baby Unit.

- **July 2010** Mother and baby report mum – difficult life events, episodes of low mood, isolation but no cp concerns

- **August 2010** Kieron's significant development delays. Nursery note Kieran -failure to put on weight, poor physical conditions within the family home and the unusual number of adults in the home

- **September 2010** home visit warned home condition- situation improved
- **Dec 2010** Mum is receiving counselling for childhood traumas Health Visitor agreed to re-visit Kieron referred to the Community Paediatric Team to assess his on-going developmental delay

- **January 2011** mum begins relationship with the man who later killed Kieron

- March 2011 housing application following a significant and violent family row involving her brother and step dad who suffers from cerebral palsy and epilepsy

- HV makes cp referral- threshold is thought not to be met referred to the Family Support Team of this Children's Centre to address developmental delay and the lack of stimulation
- **March 2011** development assessment: Kieron assessed to have global developmental delays, visual concerns; and microcephaly.
- **May 2011** Louise Barley and Kieran move into their own home
- GP received a letter from the Psychiatric Clinic concerns: history of depression and three overdoses; pregnancy was unplanned ; overcrowded. And Ms Barley's seizures may be manifestation of distress and difficulties in coping'
- **Kieran's step father goes to a GP** – cocaine- given advice . GP did not know child in his care
- **17th May 2011** a doctor at Birmingham Children's Hospital observed bruising on Kieron's back
- **28th May 2011** Kieron was seen at Hospital with an injury to his shoulder. Mum said Kieron had fallen, struck his head on the corner of a settee and has gone 'floppy and crying. Mum took him back – vomiting-
- **6th June 2011** Louise Barley and Kieron were seen by the Community Paediatrician Kieron has cerebral palsy
- **9th June 2011** when a 999 call

- Kieron’s life

Final Overview Report BSCB (2016)

- **June 2011**

little Kieron died aged 22 months

- **Post mortem-** two significant injuries spinal fracture three weeks before his death and brain injury during the final days of his life.

- Injured caused by step dad in two fits of anger and mum had covered up though she gave differing accounts after her sons death and claimed not to know.

What if you had been involved

- What are your reflections- what were the key issues, patterns and issues of concern?
- What were the challenges?
- Were there missed opportunities?
- What would you have explored and with whom in order to understand risk and needs?

Toxicology

- **Known toxic**
- **dose or and level** of exposure

interaction that creates toxins.

The **challenge in safeguarding children:**

Identifying and making sense of the toxic ingredients:

- type,
- amount,
- dimensions of,
- its composition,
- interaction with other factors
- the impact of toxicity in different families.

Truism

- Family environment, functioning, relationships and dynamics are critical to a child's health, safety and well-being.

- Parents health, safety and well being or chronic or acute crises will impact directly or indirectly the wellbeing health and safety of a child.

Toxic Trio' risk – or not-

of apocalyptic impact on children's lives

- domestic abuse,
- mental ill-health
- substance misuse

common features of families where harm to children has occurred.

The overlap between these parental risk factors are prevalent in a number of cases of child death, serious injury and generally poorer outcomes for children across all ages (Brandon et al, 2008).

Co-morbidity: Co-occurrence between the 'toxic trio

EG

- Approximately a third of mothers (31%)
- Approximately a third of fathers (32%)
- in these families experiencing domestic abuse disclosed either mental health problems, substance misuse, or both." **CAADA Research Report, February 2014**

A review of Serious Case Reviews (2007-2011) found nearly ¾ of children lived in families where two or more of these issues were present.

Ofsted 2011

ANALYSING CHILD DEATHS AND SERIOUS INJURY THROUGHABUSE AND NEGLECT: WHAT CAN WE LEARN?A BIENNIAL ANALYSIS OF SERIOUS CASE REVIEWS 2003-2005

- 12% of children were named on the CPR
- 55% of children were known to children's social care at the time of the incident
- The families of very young children tended to be in contact with universal services or adult services
- Failure to reach or provide effective services to older children
- Long term neglect: failure to take into account past history - '*start again syndrome'*
- Over half of the children had been living with domestic violence, or parental mental ill health, or parental substance misuse. These often co-existed.
- Childhood adversities not known to practitioners

DCSF

January 2008

Ofsted- outcomes scr 2009

- 35 / 50 known to social care. All were known to universal services
- Professionals failed to consider the situation from the child's perspective: they failed to see the child and, where possible, talk to them
- Too often professionals took the word of parents at face value without considering the effects on the child. There were factors in the families involved related to drug and alcohol misuse, domestic violence, mental illness and learning difficulties which were often not properly taken into account in assessing risk and considering the impact on the child.
- Agencies **poor** at addressing the impact of chronic neglect and intervening early to prevent problems from escalating.
- For a number of older children subject to serious case reviews the problems in the family had been evident for some years.

POOR UNDERSTANDING OF:

protection signs,

symptoms and risk factors

Responding reactively to each situation

- Responding to the situation rather than studying and acting in the the context of history
- No single agency had a complete picture
- Accepting unacceptable care standards
- Little direct contact with children to find out what they thought and felt

- Professionals uncertain in tackling complex chaotic families
- placing too much reliance on what parents said
- Families often hostile and developed skilful strategies in keeping professionals at arms length
- Little assessment of attachment
- Multiple assessments and plans but no clear expectation of what needed to change —and what the consequences of no change would be

- Neglect not challenged: incomplete picture, reactive working, resignation.

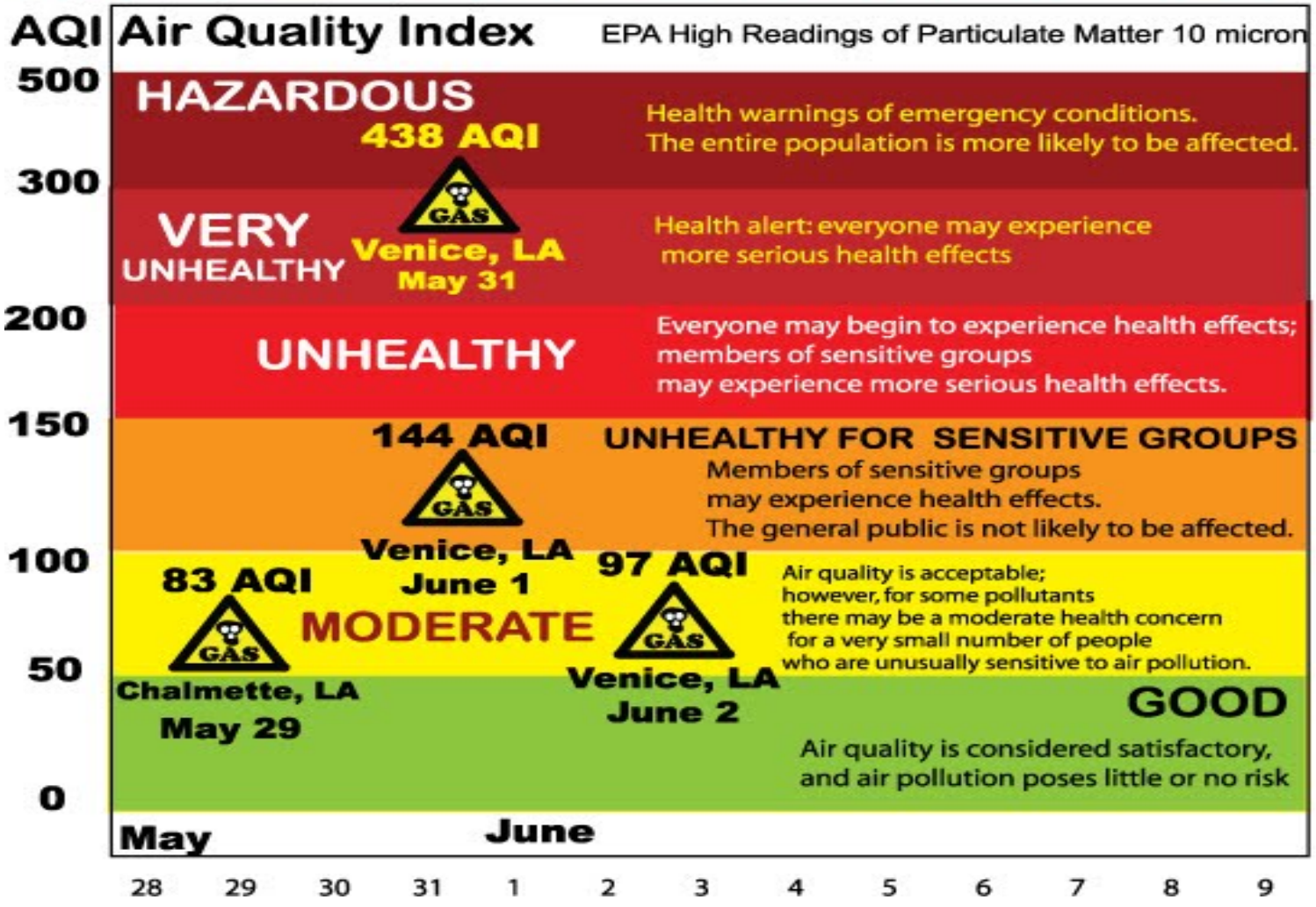
- Sexual abuse unrecognised, signs not noted, not referred to specialist agencies.

- Patterns of engagement: missed appointments, moving around, non-appointments, non--engagement with professionals

- Siblings not protected

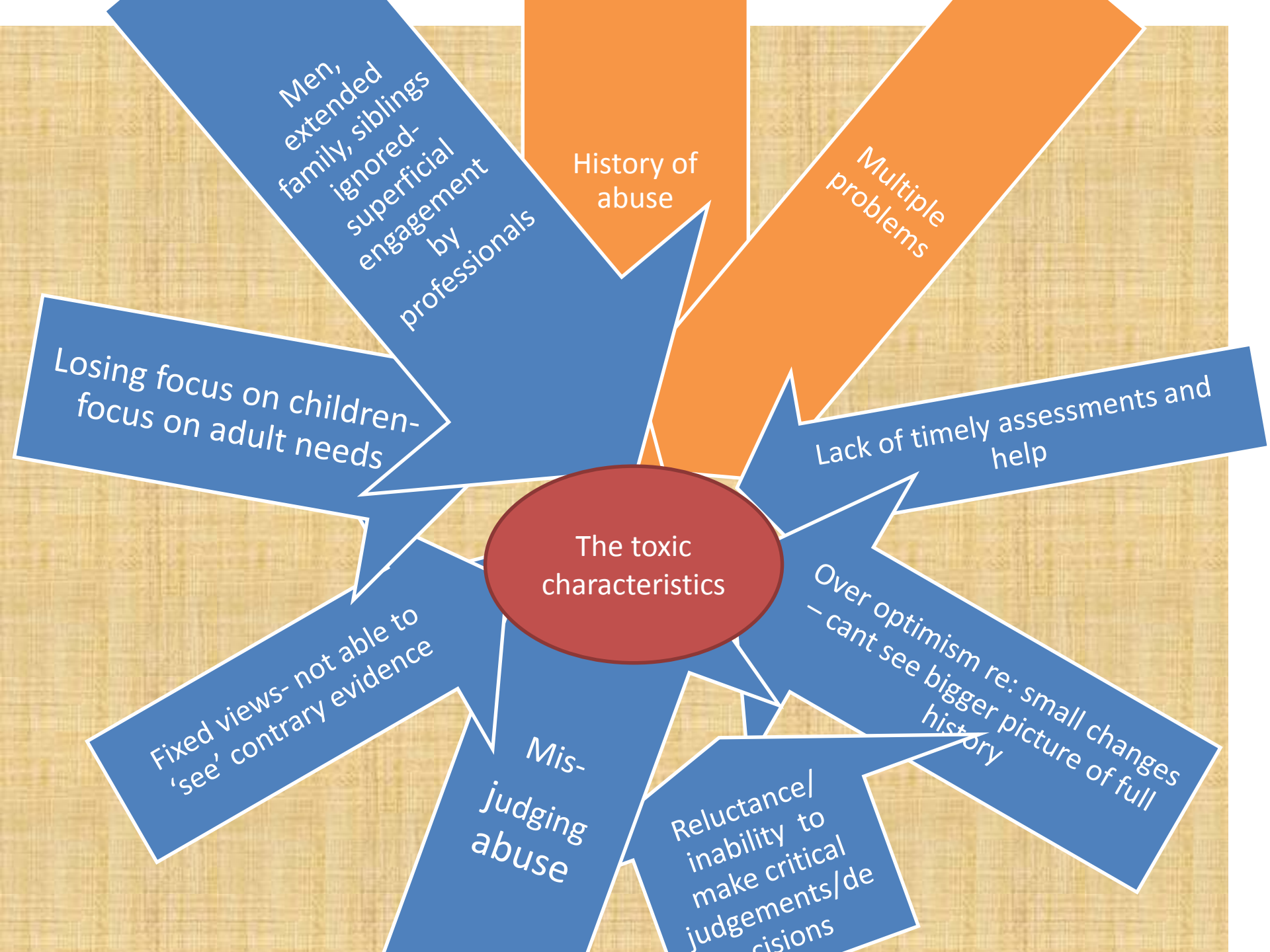
TOXIC GASES Hit "Hazardous" Level

Particulate Matter (10 microns) in Gulf Air (EPA)



Other factors may also be present with one or more of the trio interacting

- Learning disability:
  - **25-40% of adults with a learning disability have mental health problems**
- Cultural community and family beliefs
- Physical parental ill health
- Child ill health /disability


Men, extended family, siblings ignored- superficial engagement by professionals
History of abuse
Multiple problems
Losing focus on children- focus on adult needs
Lack of timely assessments and help
The toxic characteristics
Fixed views- not able to 'see' contrary evidence
Over optimism re: small changes – cant see bigger picture of full history
Mis-judging abuse
Reluctance/ inability to make critical judgements/de cisions

The scale of vulnerability

- **1,796,244 children in England live in households where there is a risk of domestic violence**
- **250,000 to 978,000 children have a parent who misuses drugs**
- **920,000 to 3.5 million children in England are affected by parental alcohol problems**
- **50,000 to more than 2 million children are affected by parental mental ill-health**

  - *Source: How safe are our children? NSPCC 2014*

Children: initial CP plan in England 2014-2015

Category	Number of Children
Neglect	22,230
Physical Abuse	4,350
Sexual Abuse	2,340
Emotional Abuse	16,660
Multiple categories	4,110
Total number	49,690

A young person's perspective

- TOXIC is:

- Bad social worker
- Bad manager
- Bad system

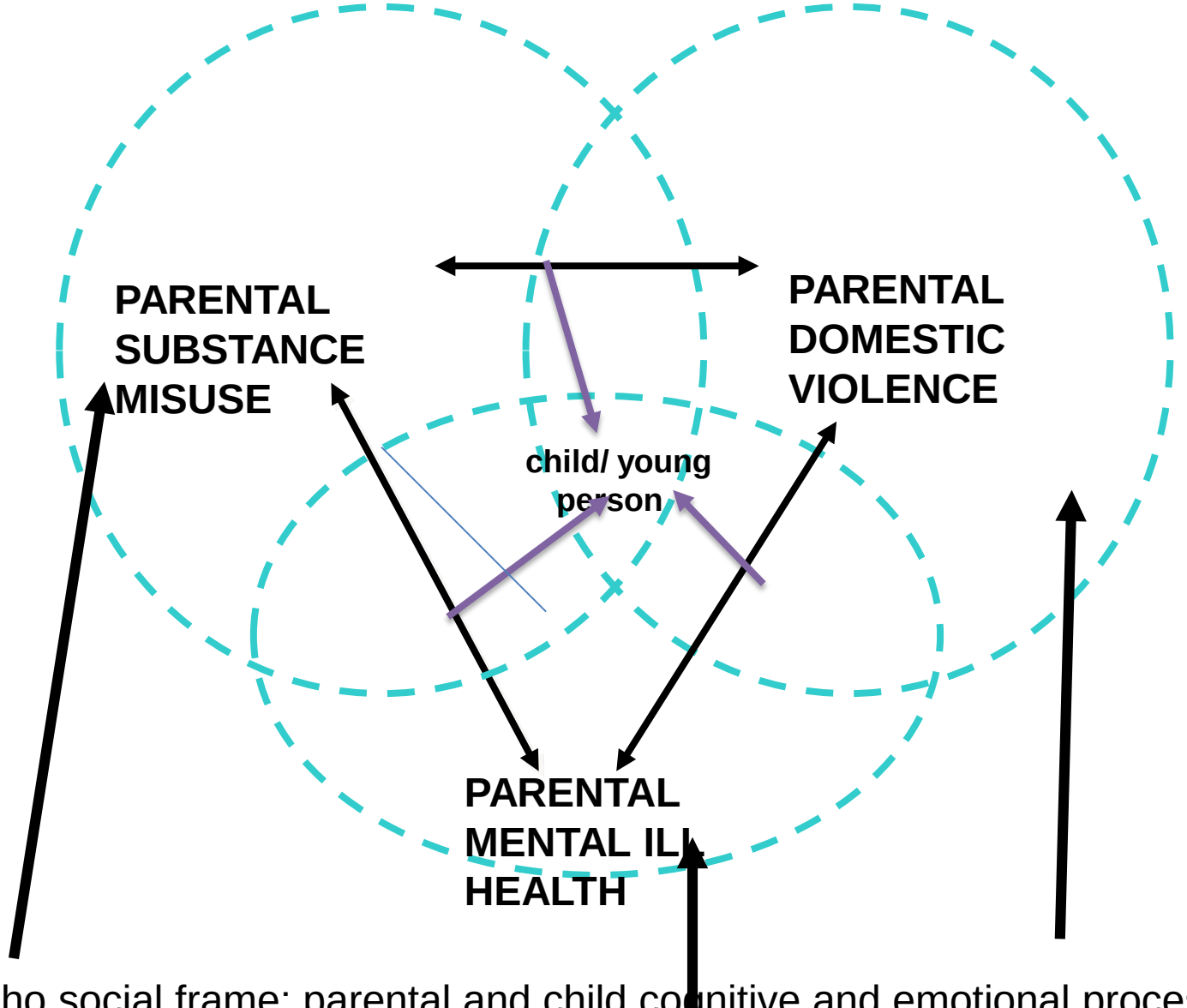
We have many other narrative pressing on us, for example:

- Indicators thresholds
- Not discriminating
- Human rights
- Checks and balance of the CA1989
- Impact not clear
- Professional judgement
- Evidence
- Analysis
- Skills
- Theories
- Research
- Supervision
- Effective solutions
- Workload
- Perception of social workers

EG

- The challenge against notion of "failure to protect“ as it focuses primarily on the responsibility of the abused parent, usually the mother, who is often herself at significant risk (Hester et al, 2006).

- Research on domestic violence, however, has consistently shown that supporting the non-abusive parent helps protect the child.



Psycho social frame: parental and child cognitive and emotional processing woven with personal values/ cultural from family and external and religion values, history **AND** **Protective factors and resources**: family & social network, coping strategies, emotional resilience. **AND** Texture weight of the concern

- How do we know if children are at risk with parents where there is evidence of the toxic trio?

CHESHIRE WEST AND CHESTER LOCAL SAFEGUARDING CHILDREN BOARD SERIOUS CASE REVIEW CHILD A OVERVIEW REPORT Child A (2016)

Child A sustained an injury that later required hospitalisation and surgical interventions. Child A became unwell and required hospitalisation and emergency treatment. This treatment was re.bleeding on the brain, which was the result of a head injury sustained in a fall earlier that day.

Family

AM –mum

Two older children were removed and adopted

(mum had suffered domestic abuse 2002)

Am and new partner

Child 1

Child A

A number of younger siblings

- **2004** The oldest child in the family had been subject to Child Protection planning in under the category of neglect.

- **2007** AF had allegedly had a knife and 'nicked' AM

- **2010** A Referral by health visitor to Children's Social Care in relation to a man who was thought to have been involved in sexual abuse . Checks, advice, no further action

- **2012** (TAF) following concerns raised by the Health Visitor about the home conditions and the children's failure to thrive

- The hospital told Child A had a habit of coming downstairs at night to watch TV. In the early hours of the morning in question Child A's father (AF) was asleep on the sofa and was woken by Child A saying that they had hurt their head, and that they would not let father look at their head.

- AF also reported that Child A had told him, whilst on the intensive care ward, that they had got up to watch a TV programme and that they had climbed onto a kitchen work-surface, then on to the refrigerator to reach a high cupboard to get sweets. They had fallen from the refrigerator onto the hard surface kitchen floor, hitting their head on the floor.

- Parents informed enquiries by police and CSC

- Police go to family home assess conditions unsuitable. Children taken into police protection and subsequently ico granted

- **October 2012** AM disclosed to the Health Visitor that AF comes home 'drunk' and urinates in inappropriate places.
- Health Visitor -inconsistent care and that there were no routines or boundaries in the home. AM said she did not want family support.
- The Health Visitor contacts Family Support Worker about trying to engage with the family.
- Child A had two appointments with the GP: accident where they had fallen downstairs; the second regarding a referral to the Community Paediatrician for undiagnosed ADHD.

November 2012 Health Visitor told by AM that Child A and another sibling were copying their father and not using the bathroom and toilet appropriately and that bedrooms were sometimes soiled.

December 2012 family did not want TAF support and that parents were reluctant to engage. Joint home visit first priority was to establish a relationship with the parents to begin to address the needs of the children.

January 2013 professional's meeting :concerns

- long standing issues in relation to negative parenting,
- AM's disclosure historic sexual abuse as a child.
- removal of two older children

- Agreed: TAF and allocated support worker
- Another TAF meeting: Child A could be frustrated and angry and some sexualised behaviours.

January and September 2013 regular TAF meetings

- - the family appeared to be engaging with plan
- Webster Stratton parenting course and conditions in the home appeared to be improving.

April 2013 AM tells Health Visitor: no money to buy food as AF was unable to go to work after falling of his bike whilst 'drunk'.

September 2013 TAF meeting agreed positive changes and that a period of time was required to assess whether parents were able to manage independently. A decision was taken to close the TAF

- **November 2013** a new baby was born
- Concerns regarding the children's appearance and behaviour, appeared hungry,
- School: Child A thin and pale, a sibling 'sad and quiet'
- Concerns raised with the parents
- FSW :home conditions assessment and a graded care profile and suggests TAF.
- Post-natal visit - room to be dirty and cold, dogs were barking loudly, the children were disruptive and the parents were shouting.
- Professional's meeting was held: children's emotional wellbeing, lack of food and eating patterns, tiredness, clothing . Children's explain: urinating in their room-afraid of dogs. TAF reopened.
- Home visit- shouting, parents perceived to be like children
- Home Conditions Assessment was completed score of 23 from a possible score of 90.
- Child A referred to the Community Paediatrician.
- **January 2014** –TAF meeting. Continued work with children referral to another agency , meals were same children unkempt and dirty
- **February 2014** : visit home conditions : cold, dirty and cluttered. Referral to CSC discussed . FSW1 later observed AM with Child A at the Children's Centre,:being roughly handled with AM saying that it was because of Child A's behaviour that the children would be removed by Social Care.
- Referral to CSC
- **March 2014.** CAHMS – found not to have any mental health needs, and was discharged
- Child A was referred to another specialist services

- A: Faltering weight and growth, and behavioural difficulties: anger and hostility towards their siblings, inability to control temper

All the children:

- failure to maintain weight gain;
- speech and communication.
- Parents chaotic relationships with children, unable to establish routines and boundaries.
- AM lacked emotional warmth and lack of emotional bond particularly as they grew older. AM acknowledged and attributed it to her childhood experiences: child sexual abuse from the age of 2 by her dad and other men.
- Dad primary carer detrimental impact on ability to work and benefits
- Dad drank excessively on occasion
- 2 historical recorded incidents of domestic abuse between parents. Mum denied any abuse. Some concern re dad's controlling behaviour esp. finances and sexual relationship pressure
- AM did not trust professionals as a result of losing care of her older children

- **CSC threshold not met**: parents engaging , some improvements had been made.

Advised: TAF should include unannounced visits and to complete graded care profile

- **March 2014** Child A was seen by the Consultant Paediatrician : ***no underlying cause for faltering growth*** . Recommended monitoring
- Unannounced visits some improvements to the home conditions . Child A and a sibling **not using the toilet appropriately and fighting**(AM reported that Child A had 'strangled' the sibling the day before).
- Child A - specialist work around wishes and feelings,
- **May 2014** TAF meeting. Parents- children's behaviour deteriorated :taking food out of cupboards. **Parents refuse responsibility insist children's 'fault'**. The parents felt pressurised by professionals
- **June 2014** professionals meeting F : man who had allegedly been involved in sexual behaviours with children had been in the family home. CSC said parents should be advised
- Referral to CSC again following health checks
- Community Paediatrician: Child A lost weight, advice keep food diary referred to Dietician
- Connors 3' questionnaire with regard to behavioural issues

- Strategy discussion- single agency assessment family continued to receive intensive family support
- **August** Family move home
- HV visit- a child choking; parents were not responding
- SW2 found writing on a bedroom wall 'I hate my mum because she hurts me every day – and that's true'
- SW2 visits - youngest sibling face down on the floor feared that child might be dead. Mum unconcerned
- Strategy meeting – agreed s47
- Home visit parents say children stealing from the fridge. some of the children had minor injuries, parents give unconvincing account of bruising to one of the older siblings
- **September** school concerned parents withholding information and Chid A's siblings who appeared to be a sad and isolated child

- **September:** Initial Child Protection Conference
- five visits per week agreed
- minimal change in 18 months
- Parents disputed all the points .
- **Risks:** poor supervision - fighting amongst some of the children, lack of routines and boundaries, basic needs not consistently met, weight loss, the size of the family, emotional impact on the children of being told they will be taken into care by parents, parents displaying no motivation to change and being defensive and uncooperative.
- Unanimous decision CP plan: category of neglect
- Core group:

- intensive family support three weeks

-Primary School 2 reported one of the children had sent a letter to a fellow pupil saying that they wanted to 'have sex with them' – it appears that the older siblings had colluded in sending the letter. The same sibling was also excluded from school for two days for hitting another pupil.

- Same day child A went to school ill taken to hospital and he had bleeding to the head

What key lessons do you learn from the scr?

What are your reflections on why this case unfolded as it did ?

What key lessons do you draw up from this scr?

KEY LESSONS

- Rule of optimism
- Some change for short periods
- Disguised compliance recognised
- No parenting capacity assessment
- Strong focus from professionals on the home conditions, the presentation of the children and their physical health
- Awareness of lack of warmth by mother
- 'Behavioural and sexualised behaviours not understood or explored

- This '*may have had the perverse effect of professionals not exploring the underlying causes of neglect, emotional abuse and the behavioural problems of the children' ??????!*

- Professionals did not know what else could be offered to AM
- CAMHS focus on identifying a recognised mental health condition resulted in the causal factors for Child A's behavioural issues remaining unexplored

- Lots of assessment tools such as the Edinburgh Depression Inventory, Domestic Abuse Risk Assessment tools and other risk/harm assessment tools were used by professionals

- But did they build a complete picture of risk/harm and protective factors within the family?
- Clear issues of emotional abuse obscured by responses to neglect that were focused on seeking visible improvements.
- impact upon the children the causal factors and impact of emotional abuse was not fully explored.

- '*it may be helpful to revisit these categorisations to support the hypothesis that emotional abuse can stand alone from neglect and has a significant and ongoing impact on outcomes for children*'

What else?

- What steps would you take to avoid such practice?

- Thresholds and types of abuses presenting
- Whose role is it?
- Drift
- Start again- the same interventions- haven't worked
- Assessment tools, procedures only good if workers have ability to apply and evaluate meaning
- Superficial assessment and superficial interventions

Lack of meaningful exploration and analysis:

- Domestic abuse
- Alcohol misuse
- Family dynamics and roles and relationships
- Focus on the presenting – including history
- Children's behaviours and expressions
- No Focus on underlying or the interaction of what factors to create symptoms

- Quality of services esp. counselling and exploration of wishes and feelings

Causal and presenting and underlying

Problem or Solution?

Combination skills

- **Intuitive**- enables rapid decision-making without conscious awareness or effort;
- **Critical thinker**- the ability to achieve understanding, evaluates viewpoints, and solves problems;
- **Creative**
- **Self-Aware**-an understanding of one's own strengths and weaknesses;
- **Social Skills**-the ability, to assess people's strengths and weaknesses, the use of communication skills, and the art of listening etc

"Let me embrace thee, sour adversity, for wise men say it is the wisest course."

William Shakespeare Henry VI,