Overview and Analysis – Star

Learning Lessons Review: Summary of key issues

What was the story?

- Star died following injuries sustained by her mother's partner (Savannah) who was found guilty of Star's murder. Star's mother (Frankie) was found guilty of causing or allowing her death.
- Star had a troubled life, she was moved around different households and had numerous different people caring for her.
- Frankie and Star's father separated when she was four months old. She was their only child.
- Frankie and Savannah began their relationship when Star was five months old.
- When Star was eight months old, the family were referred to Children's Social Care, due to reports of domestic abuse between Frankie and Savannah. Concerns were also raised regarding Savannah's physically chastisement towards Star. An assessment was completed by Children's Social Care with the final assessment not reporting any child protection concerns.
- At nine months old, Frankie and Savannah's relationship broke down, Star then went to live with her paternal great-grandmother.
- Star was 11 months old when Frankie and Savannah resumed their relationship. Star was removed from her paternal great-grandmother's care without warning by Frankie.
- Star remained in the care of Frankie and Savannah until her death at 16 months old.

What was going well?

- Frankie and Star received good support from the wider family.
- Star had contact with her father at her paternal grandparent's home.
- The domestic violence service acted swiftly in making appropriate referrals when a family friend raised concerns.
- Paternal great-grandmother was seen to be a protective factor and Star was reported to thrive in her care.
- Direct work was undertaken with other children living in the home and discussions were held with Frankie regarding domestic violence.
- Face to face visits during the COVID pandemic and assessments were completed.

What were we worried about?

- The potential for Frankie's needs and vulnerabilities as a first-time teenage parent and the impacts of this on Star.
- Domestic violence reports between Frankie and Savannah.
- History of domestic abuse within Savannah's previous relationship.
- Bruising reported on Star.
- Concerns raised by family members and others about physical chastisement towards Star by Savannah, and the care provided to Star by Frankie.
- Frankie struggled to cope with Star and Star would often go to various family members to be cared for.

What needed to happen?

- The impact of the parent's own experiences on their ability to care for their children was not fully explored or understood. Pre-birth assessments should have been carried out to give a fuller picture.
- Communication between agencies sharing significant information about family and Frankie's vulnerabilities to enable implementation of plans of timely and appropriate support.
- More critical thinking and challenges within and between agencies to trigger statutory multi-agency child protection processes.
- Have more of an understanding of the child's life. To do this, professionals needed to listen and explore the views of the wider family.
- Exploring the in-depth impact of domestic abuse on the child.
- To work closer with the family where the engagement was reluctant and sporadic.
- Gathering complete information and sharing before and during Child protection medicals.
- Photos given by wider family members needed to be appropriately examined and shared.

Learning for professionals and multi-agency practice

- Identifying risk in the pre-birth and post-birth period.
- Better communications between professionals with information sharing between agencies.
- More robust critical thinking and challenges within and between agencies, to trigger statutory multi-agency child protection processes at key moments.
- A need for sharper specialist child protection skills and expertise, especially concerning complex risk assessment and decision making, engaging reluctant parents, and understanding children's daily life and domestic abuse. The version of events given by parents was too readily accepted.
- The need for leaders to have a powerful enabling impact on child protection practice, creating and protecting the organisational conditions needed to undertake complex work.
- More direct work to be carried out with families, primarily to ensure the child`s voice is heard. Professionals did not clearly understand what life was like for Star, and too much emphasis was given to the voice of the parents rather than the wider family.
- Professionals should reflect more and further explore how the children and families presented themselves during visits.
- Practitioners' biases and assumptions impacted how they assessed risks to the child and made decisions about their safety
- The risk posed by new partners was not fully considered. For example, a range of historic and current domestic abuse issues was present, but the threat posed to the child was not thoroughly explored
- Ensure that all practitioners understand their role when considering allegations of bruising, including consideration of images which appear to show bruising.

Reflection for Practitioners to consider either individually, as a group or in supervision

- How do you work with other agencies to build a complete picture of what is happening in a child's life?
- What behavioural biases, e.g. confirmation bias, might impact your information sharing and seeking practice?
- Do you consistently speak to and listen to the views of family and friends who know a child well? What barriers can get in the way of you doing this?
- What assumptions might you hold about culture, ethnicity, gender and sexuality? In what ways might this affect your practice?
- What aspects of working with families with reluctant and sporadic engagement do you feel more/less confident with? What do you consider to be typical signs of parental avoidance?
- What opportunities do you have - formally or informally - to challenge decisions within your and other agencies and to consider different professionals' perspectives

Multi-agency responses for this case

- https://westyorkscb.proceduresonline.com/chapters/pstratdisc.html
- https://www.saferbradford.co.uk/media/52thisa4/pre-birth-wy-consortium-guidance-version-1.docx

Resources for professionals including all inter-agency Safeguarding procedures can be found on the Safer Bradford website.

https://westyorkscb.proceduresonline.com/index.htm

Multi-agency training

Training, guidance and resources for professionals are also available on the safer Bradford website Safer Bradford - Learning / resources