South Tees Safeguarding Children Partnership

CHILD SAFEGUARDING PRACTICE REVIEW
EXECUTIVE SUMMARY REPORT
LIAM
APRIL 2021

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Introduction

This is the executive summary of a Child Safeguarding Practice Review (CSPR) concerning Liam. In May 2020 when he was aged two years and 11 months, Liam was taken to the Emergency Department (ED) of South Tees NHS Foundation Trust Hospital (STHFT) by his Paternal Grandmother (PGM). He was floppy and unresponsive. Liam had been in the sole care of his father (Father) prior to PGM bringing him to the ED. PGM gave a history of Liam falling from a ladder however hospital staff considered that Liam's presentation was potentially due to a seizure or to ingesting drugs. Subsequent toxicology of Liam proved positive for multiple substances including cocaine. Whilst it is possible that this was accidently ingested by Liam the possibility of cocaine administration cannot be completely ruled out.

Tragically, whilst Liam was still in the ED Father took his own life.

Liam along with his siblings was subject to a child protection plan (CPP) at the time of the incident. He recovered and was discharged from hospital into the care of the local authority.

Working Together to Safeguard Children 2018 guidance sets out the process for national and local reviews. Local safeguarding partners must make arrangements to identify and review serious child safeguarding cases within a defined criteria, and, in their view, raises issues of importance in relation to their area.

The South Tees Safeguarding Children Partnership (STSCP) led on safeguarding arrangements and the local review. This case was brought to the attention of agencies for consideration as a CSPR in May 2020. As part of this process the STSCP conducted a Rapid Review and it was decided that a local CSPR was appropriate.

The independent reviewers of the CPSR were asked to consider six terms of reference:

1. **How organisations interacted and worked with the family and each other.**
2. **Were single and multi-agency assessments and thresholds effective?**
3. **Was parenting capacity assessed and considered?**
4. **How effective were agencies in identifying, understanding and responding to contextual safeguarding risks?**
5. **Was multi-agency communications and information sharing appropriate, accurate and acted upon. How well was information shared, understood and responded to between agencies?**
6. **Consider whether, or to what extent, the Covid-19 crisis impacted either on the circumstances of the child or family or on the capacity of the services to respond.**

Additionally the CSPR multi-agency governance panel asked that the CSPR considered whether or not learning from a number of recent Serious Case Reviews (SCRs) in respect of children whose parents misuse drugs has been 'embedded' into policy and practice.

Liam's mother (Mother) contributed her views and perspective to the review.

The lived experience of Liam and his family life

There has been significant agency involvement with Liam's family since 2005 in relation to domestic abuse, parental mental health, neglect, substance misuse, offending and criminal exploitation.

Although too young to express his feelings in words, Liam's daily lived experience involved domestic abuse, anti-social behaviour, 'stranger' violence against Father within the family home and parents who were affected by drug and alcohol consumption. Liam was not always safe and secure this would undoubtedly have had an impact on his emotional and physical wellbeing and development.

This was borne out at his developmental reviews when Liam was noted by Health Visitors to be showing poor fine motor skills, problem solving, and speech and language development and poor personal and social skills. In addition, he was born with a condition affecting his feet, which meant that he had to wear a 'bar' on his legs overnight as part and he has to wear specialist boots until he is 4 years old. Liam was not registered with a dentist and did not know what to do with a toothbrush and toothpaste when handed to him. He was not taken to seven out of 15 health appointments.

Partners were aware of Liam's developmental and unmet health needs which indicated that his day-to-day life may not always have been safe, secure and nurturing. However, there was no consistent consideration of the impact on Liam's development of the fear and anxiety that he experienced on a regular basis. Instead, the significant issues of his parents and also those of his vulnerable older sibling, was often the main focus of professional assessments, decisions and interventions. This was compounded by an 11 month period when Liam was not seen by any professional and he was effectively invisible. Given these factors, it was essential that Liam was afforded regular, timely and appropriate early intervention, support and protection, to allow him to reach his full potential.

Liam's Mother's mental health was poor and deteriorated significantly in 2019 and this would also have affected her ability to be a 'present parent' for a two year old. The sad loss of her own mother with whom she was very close badly affected her. Mother has endured two long term violent relationships with the fathers of five of her children. The domestic abuse in her relationship with Father was prolific and sometimes violent and the children were present during some of the incidents. Mother had used drugs for many years and had previously been arrested for drug related offences. In 2012 the children went to live with their father because of her drug use. They returned to her care later in the same year.

In 2020 an older sibling who lived elsewhere with his father (Mother's ex-partner), briefly came to live with Mother, Father, Liam and three of his other siblings. The older sibling was extremely vulnerable to criminal exploitation and was involved in serious criminal activities. The potential additional risks and strain caused by this move were considered alongside other contextual safeguarding risks for the purposes of this CSPR. This was at a time when Mother was already struggling to cope and this additional significant factor, in reality, was not manageable. Unfortunately, professionals did not recognise this and act to support or intervene.

Father was a drug and alcohol user. He was known to the police and his anti-social behaviour caused problems for his neighbours. It is of note that Father denied having children to some of the services he accessed including his GP and mental health services.

There was limited agency or multi-agency analysis of the relationships between Liam and his parents and no recording to explain how home 'felt' for Liam or how it appeared descriptively i.e., was it clean and warm; was there an 'atmosphere', what were the children's sleeping arrangements? Liam's lived experience was not explicitly discussed or considered in assessments or decision making.

Key Learning and Recommendations
Partners should be cognisant of potential parental coping strategies including disguised compliance when considering the voice and lived experience of the child.

The STSCP may wish to develop guidance to ensure partners prioritise consideration of all potential impacts and particularly cumulative and contextual factors when interpreting the voice and lived experience of the child.

Summary of agency involvement with Liam and his family

Children's Social Care

Middlesbrough Children's Services (CSC) had been involved with the family since 2005, with Liam and four of his siblings spending periods of time as subjects of child in need, child protection arrangements, Public Law Outline (PLO) and Care Proceedings.

Liam was subject to a Child in Need (CIN) plan at birth with three CIN meetings between November 2019 and February 2020.

In May 2018 CSC completed a single assessment and recorded that the house was in a state of disarray, Father had been assaulted by unknown males in the family home and arrested but not charged with an alleged assault. It was recommended that if further incidents of domestic abuse or substance misuse were reported a section 47 enquiry should be considered. However, there were five further referrals to CSC (July 2018 to March 2020) before a section 47 enquiry was undertaken. These referrals were in relation Father's overdose and domestic abuse incidents and were linked to the ongoing single assessment, and not acted upon through a section 47 enquiry.

In October 2019 the single agency assessment identified that four of the children should remain on a CIN Plan; however, Liam's older sibling was not deemed at risk of harm due to him residing, at that time, in the care of his father. Early help had been involved and consideration was given to the case 'stepping down'. Due to a decline in Mother's mental health during the assessment process, it was determined that tier four services were required.

In March 2020 a child protection strategy meeting was held with an outcome of an Initial Child Protection Case Conference (ICPC) being convened and legal advice sought. The children became subject to CPPs in early April 2020. The case was presented to legal gateway panel in April and the children became subject to PLO with a review PLO meeting held in May 2020. At this time both parents were engaging with substance misuse services. (Care proceedings were initiated in late May 2020 due to Liam's presentation at hospital, Father's death and the family history).

Although PLO was initiated on three separate occasions this did not result in public law proceedings being initiated. As part of the drug test results in May 2020 when Mother and Father disclosed a significant amount of illicit substance misuse legal advice was that the threshold was not met to issue proceedings. The rationale for this decision was that Father was not living in the family home, however a day later he was seen at the home by a health visitor (HV) and was caring for Liam and his siblings with Mother nearby in a neighbour's garden.

The legal gateway panel were advised to undertake another four weeks of PLO prior to considering issuing proceedings. This was 10 days before Liam was admitted to hospital. There is no evidence that the decision was challenged or reviewed the following day when Father was seen at the family home with the children.

Police

The family were well known to the police for domestic abuse, offending, anti-social behaviour and Liam's older sibling's vulnerability to criminal exploitation. There were numerous '999 calls' to the police from the family home which were reported by Mother and Father to have been accidental.

Adult mental health services

Mother experienced poor mental health and was prescribed anti-depressants by her GP, this worsened following the death of her mother. She was assessed for but found not to be experiencing psychosis by secondary mental health services. She received a provisional diagnosis of 'Adjustment disorder with prolonged depressive episode'. Father attended some of her mental health assessments and appointments with her. She was discharged by her Community Psychiatric Nurse in December 2019 and referred to a bereavement counselling service.

Mother denied that she used drugs and/or alcohol to mental health professionals.

Father had intermittent contact with mental health services since 2010, with a long history of substance misuse and emotional dysregulation including self-harm since the age of 15 or 16 years old. Other issues included excessive alcohol misuse; history of over dosing; excessive substance misuse. He reported 10 years of intermittent depressive features; some self-harm episodes and medication. There was no evidence of a mental illness.

Emergency Department

Father attended the ED on a number of occasions whilst under the influence of drugs/alcohol and on one occasion due to self-harm.

Mother attended the ED four time within the timescales of this CPSR. In 2018 she attended with an unusual injury which she said had been caused by a fall. No discussion or consideration of potential domestic abuse took place.

Two weeks later Mother again attended ED with a nasal injury. It was recorded that she was 'pushed' by her partner two weeks previously then sustained a further injury 'play fighting' at home. Mother was referred to the Ear, Nose and Throat team for a further assessment who recorded the history as a domestic assault.

Substance misuse services

In April 2020 as a condition of the child protection proceedings Mother and Father engaged with the substance misuse service (CGL). Mother reported misusing illicit medication and Father reported misusing alcohol, cocaine and cannabis. Father reported one child living in his care and that this child was subject to a CPP.

Structured treatment was offered to Mother and Father. Both were advised of the danger of drugs to children and the safe storage of drugs was discussed. Mother and Father were offered a safe storage box which was not collected by Father but was by Mother.

By May 2020 Mother reported a reduction in her use of illicit medication.

Father informed CGL that he had reduced his drug use and was residing at PGM's address but he missed his next appointment and by May 2020 reported that he had relapsed.

Domestic Abuse Services

Mother is recorded as having spent a period of time in a women's refuge in 2012 and she disclosed that she had used the refuge as a place of safety several times since then.

In 2014 Mother was offered talking therapies and was signposted to the 'EVA' programme for domestic abuse. She was seeking support to maintain separation from Father.

Also in 2014 a multi-agency risk assessment conference (MARAC) identified Father as a domestic abuse perpetrator. There was no evidence to show any referral to services for Father in respect of the domestic abuse e.g. a perpetrators programme.

Other health services

Liam's condition meant that he was involved with services regarding treatment for his leg condition.

Mother and the children were registered with a different GP practice to that of Father. Liam had limited contact with his GP.

Key learning from this review

The key lines of enquiry for the CSPR were explored through the process of considering the details submitted by agencies as part of the Rapid Review and also from a practitioners learning event.

Term of Reference 1: How organisations interacted and worked with the family and each other.

This is the fourth review in Middlesbrough since 2015 where a young child has ingested substances. The previous reviews identified cumulative neglect; impact of the abuse of prescription drugs on parenting, fathers avoiding professionals and drug treatment, role of fathers in the lives of children and professionals' absence from multi-agency meetings.

The practitioners who participated in the learning event looked at the other reviews and identified numerous overlapping areas of learning and whilst there was a multi-dimensional approach in cascading learning, there remains a challenge in embedding learning from reviews to change practice. Practitioners did recognise that staff turnover was a challenge to embedding learning from reviews, and also that delivering the right training to the right people at the right time was difficult given the complexity of the cases and assisting practitioners in understanding how complex some case can be.

There was inconsistent practice in respect of Liam not being brought to appointments at the GP practice and physiotherapy appointments. The Physiotherapy team were proactive in following up non-attendance. The Trusts Child Not Brought (CNB) Policy was considered, but missed appointments were generally followed by an attendance making concerns regarding medical neglect more difficult to escalate.

The police dealt with a number of domestic abuse and other incidents at the family home but details were not always shared with partners and this limited the effectiveness of multi and single agency risk assessments. There is an agreed process of what incidents will result in sharing of information, but this will not inform a collective picture.

CGL reported that Father missed a number of appointments following an initial discussion with him. He later advised the service that he had reduced his cocaine use, which was shared with CSC, but it is not clear if they shared information of his non-attendance or relapse. There was good liaison between the service and CSC with regard to Mother's engagement.

Individual agencies identified non-engagement by Mother and Father despite substantial demands that the family placed upon their services. Had information sharing been more effective between agencies this pattern of non-engagement would have been recognised and multi-agency decision making would have been more effective.

There was a lack of discussion, curiosity and challenge around drug misuse at CIN meetings in late 2019 and early 2020. This was likely due to CGL not being in attendance and whilst Mother attended some, Father did not. Similarly, GP practices for both parents were not invited to the ICPC in 2020 nor asked for any information for this or the CIN meetings. This was important as Father had told his GP that he did not have any children and this would have been corrected and have added context to risk assessments if the GP had been invited.

The decision not to undertake a section 47 enquiry despite further serious incidents and referrals and the decision not to pursue PLO were key events. Whilst the legal responsibility rests with the Local Authority, the CSPR established that at times agencies were not in agreement with CSC decision making but there was no formal challenge. The CPSR has found that relevant information was not shared which would have informed the decision to challenge.

The practitioners who participated in the learning event recognised that the parents had shown disguised compliance and minimised situations to professionals, particularly to the police. The practitioners recognised the value of effective information sharing to inform assessments, decision making and professional curiosity in exploring incidents and interactions with families.

Key Learning and Recommendations

The STCP should seek assurance from partners about how and when learning from previous SCR/CSPR's will be embedded into practice.

Partners may wish to seek assurance that management oversight evidences robust supervision, professional scrutiny and challenge and the difference both make to outcomes for children is also evidenced.

Terms of Reference 2: Were single and multi-agency assessments and thresholds effective?

As described there has been a significant agency involvement with the family since 2005, and in addition, the police received 57 calls for service from this family over the period of this review which indicates a level of chaos and danger within the family home.

Liam and his family also moved home many times which led to children moving schools. The children have experienced little stability in their lives and there was inconsistency in their living arrangements as well as the care they received.

Domestic abuse was a significant feature of Mothers relationship with Father and also with the father of Siblings 4 & 5, who spent a considerable part of the relationship in prison.

Mother presented to the ED with injuries which were not explored as potential domestic abuse. Her explanations were accepted at face value despite Mother having told ED staff that Father had caused one of the injuries. The Ear, Nose and Throat department wrote to Mother's GP to inform them about the injury following an assault.

Mother disclosed to a number of professionals that she was a victim of domestic abuse and that Father was controlling. There was no evidence of adequate professional curiosity regarding domestic abuse, significant injuries, calls to the police and being seen in such a distressed state.

Father was present with Mother on occasions at GP and other health appointments and when professionals visited the home. Professionals did not consider that his attendance was a possible indicator of him controlling Mother. Given the known history of domestic abuse professionals should have made arrangements to speak to Mother alone to allow open conversations.

In 2018, Mothers mental health assessment concluded that she was not suffering from a psychotic episode but mental health professionals did not consider her long history of domestic abuse and the impact this would have had on her mental health. Her clinical team were unaware of her significant substance misuse which may well have impacted upon her mental health. In summary this meant that mental health assessments were not fully informed.

Father's behaviour especially whilst under the influence of substances caused concerns outside of the family home therefore it may be assumed that he transferred this behaviour into the home environment but this did not routinely feature in risk assessments.

There was a lack of understanding of the risk of separation from Father to Mother and the children and over optimism when she reported that Father had moved out of the family home in May 2020. In reality the relationship was not over and this was borne out 11 days later when the children were seen in the garden by the HV and both parents were present.

Health records reveal that on several occasions the parents were described as being under the influence of substances when seen by professionals and hair strand tests for both parents were positive for cocaine and amphetamines in March 2018.

There were also incidents where Father attended the ED under the influence of substances and alcohol use but not all were shared with CSC. However, this was partly due to the fact that Father continually denied having children and resulted in agencies missing key information of the risk he posed to Liam.

It is evident that the parents were not honest and transparent with professionals about their multiple drug use and there was a lack of professional curiosity in exploring this potential and accepting what the parents told them. Given the history of the misuse of prescription and illegal drugs, this should have factored routinely in assessments. There was also an acceptance of Father's position that he did not care for any children.

The practitioners who participated in the learning event identified that some partners were not aware of relevant information regarding the Father's drug use. Effective information sharing would have supported assessments and inform challenge of decision making by CSC.

Along with the obvious risk of consumption of drugs by Liam, there are also associated risk factors. The use of violence is common with drug supply. In May 2018, Police had attended at the house following and assault and damage to the house. In July 2018, Mother raised concerns about Father's behaviour to health professionals (TEWV) that he was getting into fights and his finger was nearly ripped off, that he had been stabbed, smashed up a local shop and had fallen out with a neighbour who is reported to be violent. Mother expressed concerns about the safety of herself and her children and was staying with a neighbour. This picture of risk and harm, not only to Father but to Liam and his siblings should have prompted action. Liam's experience of these events would have been very frightening.

Whilst medical neglect was more difficult to identify and escalate, the overall picture across agencies was one of ongoing neglect (school attendance was an issue as were home conditions). The use of letters and phone calls were mainly unsuccessful in bringing about changes. There is no evidence of

any safeguarding practice reviews to discuss the family in the GP surgery. Had this situation been shared and assessed from a multi-agency perspective, this may have increased concerns amongst professionals.

The assessment in May 2018, at the point of closing the case to CSC, recognised a number of the cumulative risks / harms. Liam had been suffering with nappy rash, the house was described as untidy and there were concerns that parents were under the influence of drugs whilst caring for children. The assessment at the time concluded that the factors highlighted did not appear to impact upon the children and their needs were observed to be met to a high standard. Given that there was no evidence of sustained change or that the parents were substance free, this was an over optimistic assessment and decision. The case was stepped down to universal services and this led to an 11 month period where Liam was not seen by any professionals. If the children had remained on a CIN plan it would have enabled monitoring and where necessary, further intervention and support and direct work to capture the children's voices and lived experiences.

A number of assessments were made by the police following calls for service, many in relation to domestic abuse. The wider cumulative picture of coercion and control was evident but not pursued by the police, accepting without a complaint, it would have been difficult to progress any investigation. Mother's feelings of being controlled and manipulated and the negative influence of Father were known across agencies. There were also numerous 999 calls which were explained by Mother and Father as mistaken, despite noises and indications of conflict. Police staff dealt with incidents in isolation and accepted these explanations and there was a lack of professional curiosity.

There was an ever-present risk to Liam from drugs. Professionals were over optimistic in accepting that drugs were not being used and validating this. Assessments and plans did not consider all information, historical perspective, potential linked violence and safe storage and use of drugs.

Whilst a number of agencies did recognise that there were multiple factors which were increasing cumulative harm to Liam, assessments and multi-agency decision making was not effective in addressing these factors.

Key Learning and Recommendations

Professionals should ensure that arrangements are made to allow safe and open conversations with people who are known or suspected of being victims of domestic abuse.

Plans and guidance around safe storage, safe use and the risks of ingestion of drugs were not adequately discussed, assessed or managed by parents or partners. Partners may wish to review existing cases and guidance for future cases.

Events and incidents were considered in isolation and cumulative risk factors were not considered resulting in Liam's lived experience not being understood. Assessments should be multi-agency and consider all information, including historical context around all cumulative risk factors. The STSCP may wish to seek assurance around this recommendation.

There were a number of missed health appointments for Liam and his siblings. Professionals may want to consider a more interactive method of working with families to ensure appointments are attended.

Partnership thresholds have since changed with discussions between CSC and Early Help services. The STSCP may wish to quality assure new processes.

The STSCP may wish to extend learning from this review to legal advisors and court services to increase awareness of the patterns and impact of domestic abuse

Terms of Reference 3 – Was parenting capacity assessed and considered?

Living with domestic abuse can affect a woman's ability to parent; and being a parent can severely limit her choices. Given this, mothers' needs as adult victims must be seen alongside their needs as the parents of (often traumatised) children. Domestic abuse can undermine and severely damage, the mother-child relationship. High levels of stress as a result of ongoing abuse can severely affect a woman's physical and mental health. Higher levels of substance abuse and mental health problems occur among this group.

Children are undoubtedly affected, requiring emotional support and reassurance which their mothers may feel too physically and emotionally depleted to provide. In addition, women's confidence in parenting skills and authority as parents may be severely undermined, either indirectly (because of the abuse witnessed) or as a tactic to break her down and control her.

In addition, the impact of substance misuse on Mother's ability to care for her children was already established. Poor mental health and co-existing alcohol/drug misuse is a recognised combination and should involve joint assessment and management in conjunction with children's services. There should also be a recognition that encounters with health and social services by people with co-existing conditions are often negative and lead to fears that children will be removed; this may be an important reason for poor engagement and requires sensitive handling.

Father sometimes denied drug and alcohol use, but in June 2018, following an overdose, assessments by the crisis team were sent to the GP stating that he was at risk of death by misadventure due to drug misuse. The information was not shared with CSC as the GP practice were not aware that he had children or a partner.

In one domestic abuse incident Mother told the police that "Father drinks a lot of alcohol which affects his behaviour. She does not leave him alone with the children". Mother reported to the police that she was more vulnerable when he had been drinking and he would become violent. Records show that they had both consumed drugs in pill form, smoked 'skunk' and drank. It was reported that Mother left the family home when Father had wrecked the house.

Whilst visiting, professionals believed that the parents were under the influence of drugs and both often denied substance and alcohol misuse.

Although concerns were regularly discussed at multi-agency meetings the impact of substance and alcohol misuse and domestic abuse on parenting capacity was not explored at these meetings.

At the January 2020 CIN meeting, professionals felt Mother was meeting the needs of the children, and her mental health was stable but there was a lack of professional curiosity around nursery attendance, domestic abuse and the misuse of substances.

CGL informed both parents, separately, of the negative effect that substances may have on parenting capacity. Mother was advised that if she felt the need to use or become heavily under the influence to ensure a safe adult takes caring responsibilities for the children but it is unclear if Father was given the same advice.

CCG records indicate that both parents were prescribed antidepressants by their GP's without any discussion about the children that they were caring for or any past history of substance abuse or domestic abuse. In May 2020 Mother reported Father had moved out of the family home while she

was trying to reduce her pain killers but is not clear if the amount or impact on her parenting was explored.

Overall, Father did not engage well with the substance misuse service, and missed appointments but Mother was far more engaged. Father did disclose his fear that the children would be taken it care. His engagement with all services was inconsistent, preventing an opportunity for professionals to assess and challenge him. His lack of commitment to engage with professionals and work towards changing his behaviours, was not escalated and pursued by professionals. It is clear that he struggled to care for himself so caring for his children would be a greater challenge. His initial engagement with the substance misuse service may have created over optimism with partners but in reality, it was superficial.

From Mother and Fathers histories there was evidence of adverse childhood experiences which may also have had an impact on their parenting capacity.

Key Learning and Recommendations

STSCP may wish to consider the Public Health England report regarding commissioning/delivering care for parents with co-occurring conditions.

The impact of mental illness, domestic abuse, drugs and alcohol on parenting capacity should be routinely included in CIN and CP plans.

The voice of the child and their lived experience should be evidenced and prioritised in assessments and care plans in a way that assesses any change to parenting capacity.

Assessments of parents should take into account historical information and the impact of trauma and bereavement on parent's coping mechanisms.

Father was not truthful with partners about his parental status and drug/alcohol use which limited assessments of his risk / parenting capacity. Partners should ensure that professional curiosity and information sharing is exercised and where necessary escalate concerns.

Term of Reference 4: How effective were agencies in identifying, understanding and responding to contextual safeguarding risk?

Contextual Safeguarding is an approach to understanding and responding to children's experiences of significant harm beyond their families.

Liam's life, at times, will have been difficult and unsafe because of regular incidents of violence to family members and damage to the house. In August 2019 the family had to be moved due to their anti-social behaviour. Mother and Father's substance misuse may have been responsible for the incidents of criminality and violence and these were not explored in single or multi-agency assessments. These external contextual factors of substance misuse, violence and anti-social behaviour would have impacted upon Liam.

Many of these issues were dealt with by multiple agencies, such as the Local Authority, community police teams and housing providers. There were numerous calls for service from or about this family and the CSPR did not establish a joined-up approach to resolving and preventing incidents or consideration of contextual safeguarding.

The review has highlighted a number of concerns in respect of Liam's older sibling including links to serious crime at the age of 14. Although referred to CAMHS, he was not brought to the appointment, assessed and the case was not accepted. The impact of his moving to the family home

would have been significant bringing added anxiety to his Mother and the external contexts which were risks to Liam and his other siblings.

Mother requested support when he moved back in as she was worried about his behaviour impacting upon the other siblings. A safety plan was developed but wasn't shared with key partners and it is not clear if there were discussions about the appropriateness of the older sibling living in the family home. Mother acknowledged that this was a tipping point for her mental health. Liam's care plan was not effective in dealing with this significant change in circumstances. In similar complex families, practitioners who participated in the learning event felt that each child should have an individual care plan to address continual risks. Practitioners also recognised the value in considering contextual risks for children of all ages, including unborn children.

Key Learning and Recommendations

The STSCP may wish to consider Working Together 2018 and detailed expectations of how local authorities, and wider partners, should respond to extra-familial harm.

Assessments should recognise contextual risks, and care plans should recognise the capacity of parents in providing support or where necessary escalating statutory interventions.

Term of Reference 5: Was multi-agency communication and information sharing appropriate, accurate and acted upon. How well was information shared, understood and responded to between agencies?

The CSPR established that at times records were inaccurate and key information was not shared effectively. More effective information sharing within and between agencies may have given a fuller picture of escalating concerns, particularly around substance and alcohol misuse, domestic abuse and mental health and potentially improved support for the children.

For example, the children's various schools shared information with CSC but recognised that the family had multiple children in a number of schools, and the Safeguarding Leads in each of the separate schools don't have a formal process for sharing knowledge and information.

CSC are used as informal conduit for the free flow of information for more serious cases. However, where the issues are of a less serious nature and are not necessarily brought to the attention of CSC, the cumulative knowledge of the family is not effectively captured. Cross school co-ordination may have made some difference.

Mother and Father were registered at different GP's practices. The children and parents had different surnames and there were different addresses for the parents. Whilst this presented a challenge for GP's in linking the family together, there were other organisations who did have an understanding of the family.

Mother's GP did attempt to share some information with CSC about her mental health in September 2019. Formal written documentation highlighting any concerns to CSC would have been expected practice but it appears it was via a phone call with a message left.

The GP practices for both parents were not adequately involved or invited to ICPC or the CIN meetings. Whilst school nursing and HV teams were involved and information is documented, it was not shared directly with GP's meaning that although recorded in the body of the record of the existence of the CP plan the flag was not applied on the GP's notes highlighting the children were on a CP plan or an understanding of their parents' relationship, current and past. The GP toolkit recommends holding quarterly GP meetings were discuss family concerned about and 0-19

practitioners should be involved. The forum would have been an opportunity to bring together information and health partners.

There was some confusion with addresses on the STHFT system, which were given as a reason for non-attendance at Liam's physiotherapy appointments. The acute trust has individual patient care records. Records are not linked between family members; however, information is shared with the GP regarding patient care within the trust. Health records for siblings were not linked, if they had been the wider picture of missed appointments could have been more informed and allowed an opportunity to escalate.

Within the TEWV electronic patient record system there is no mention of the children or the fact that Father was a parent. This was a missed opportunity in a referral to mental health services, but as outlined Father's unwillingness to disclose that he was a parent would present a challenge to professionals.

Agency records indicate that on occasions CSC did not share information and plans with partners. Examples of these include the CIN, ICPC and VEMT meetings. At the learning event CSC reported that a separate 'unit' deals with sharing information and plans with partners. It was accepted that sometimes there were delays in this process.

The HV was not aware that Liam's older sibling had moved into the family home in January 2020 or that Mother was abusing prescription drugs until after hair strand tests had been taken. HDFT do not hold any records about communications with the GP in relation to mother's prescribed medication, but GP meetings would have facilitated such discussions.

There were some examples of effective communication between CGL and CSC but there were also missed opportunities for example when Father relapsed. CGL were invited to multi-agency meetings or information was requested to inform meetings.

Key Learning and Recommendations

Partners may wish to quality assure processes to ensure that information is shared internally and externally.

The STCP may wish to seek assurance that multi-agency meetings involve all partners and information is effectively shared.

STSCP may wish to seek assurance that the current information sharing processes involving CSC are effective and timely.

Terms of Reference 6: To consider whether, or to what extent, the Covid-19 pandemic may have impacted either on the circumstances of the child or family or on the capacity of the services to respond to their needs.

COVID 19 created additional safeguarding pressures across the partnership towards the latter end of the review period but the risk factors were already known by professionals and did not change.

Core group meetings were restricted and the format changed to a "ring round" which limited parental participation and progression of the CPP. Children subject to CPP were receiving welfare calls but it is not evident what the process was for younger children such as Liam.

CSC were visiting the home but this would have been severely restricted because of health and safety assessments and limited visits to 15 minutes, but during a visit they did observe through a window that the room they could see was tidy.

At the start of COVID, 0-19 practitioners made contact with all families who had children who were subject of CPPs to determine if they were in school and to see if additional support was required.

School attendance was a continuing issue for Liam's siblings. During the 'lockdown' in March 2020 the children did not attend school. This absence of critical day to day oversight also meant that the children had 'disappeared from view.' Given the acceptance that vulnerable children should be encouraged to attend school it appears that professionals did not escalate or work with the family in achieving this. This could have relieved some pressures within the family at a very stressful time.

The substance misuse service was unable to provide face to face interventions, therefore individual appointments and group work was delivered over the phone or via video calls or scheduled online meetings. The frequency of appointments was not impacted.

Good Practice

The GP practice recognised that a sibling was on a CPP with Ophthalmology teams which led to escalation of activity when she was not brought to appointments.

Welfare checks were taking place weekly by the most appropriate member of the core group during COVID. This was a multi-agency arrangement to ensure that children subject of CPPs were receiving welfare calls, this recognised the increased vulnerabilities of children during the pandemic.

Conclusion

This is the fourth recent CSPR in the area with similar themes. The learning from these previous reviews did not prevent Liam suffering harm. The learning from this CPSR adds to and reflects some of the previous learning however an attempt has been made by the independent reviewers not to repeat recommendations but instead to provide challenge and reflection to the safeguarding partnership and to individual agencies.

Appendix 1

Consolidated summary of Recommendations and suggested actions.

1. **The STCP may want to seek assurance from partners about how and when learning from previous reviews and this review has been embedded into practice.**

The STSCP may wish to consider systems that evaluate training and learning and assesses the organisational impact and performance, the extent of change in practice, the effectiveness of transferring learning to improve skills/knowledge and the quality of the delivery and content of learning.

2. **The STSCP may wish to quality assure processes assessments, thresholds and care plans to ensure that;**

- **the voice of the child and their lived experience should be evidenced and prioritised**
- **involve relevant partner information, including historical context and all cumulative and contextual risk factors**
- **changes to parenting capacity takes into account historical information and the impact of impact of mental illness, domestic abuse, drugs/ alcohol, trauma and bereavement.**

This could be achieved, for example, through single agency or multi-agency audits or incorporating into existing Section 11/175 organisational auditing systems.

3. **Partners may wish to review existing cases and protocols and guidance for future cases around safe storage, safe use and the risks of ingestion of drugs to ensure adequate management, discussions, assessments by parents and partners.**

This can be achieved through a combination of review, audit and a communication strategy to professionals and families.

4. **The STCP may wish to seek assurance that multi-agency meetings involve all partners and information is effectively shared between and within organisations.**

This can be achieved through auditing of CIN, ICPC and CP conferences around attendees, information requested, obtained and shared.

5. **The STSCP may wish to develop guidance and raise awareness with regard to;**

- **cumulative and contextual factors when interpreting the voice and lived experience of the child and involves wider partners.**
- **extend learning to legal advisors and court services to increase awareness of the patterns and impact of domestic abuse to facilitate safe and open conversations with victims of abuse.**
- **Professional curiosity and responding to disguised compliance, parental coping mechanisms and failure to engage with partners.**

This can be achieved through the same methodology at recommendation 1.

6. **Partners may wish to seek assurance that management oversight evidences professional scrutiny and challenge and the difference both make to outcomes for children is evidenced.**

This can be achieved through single agency or multi-agency audits or incorporating into existing Section 11/175 organisational auditing systems.