South Tees Safeguarding Children Partnership

CHILD SAFEGUARDING PRACTICE REVIEW

ANGEL

PUBLISHED 2023

Child Safeguarding Practice Review

Angel

Agreed by the STSCP on 6th June 2023

Introduction to the review

1. This CSPR was commissioned because it was determined that learning would be identified for agencies in South Tees through the consideration of the case of a child who died in the first weeks of their life, to be referred to as Angel.[1] The cause of death has not yet been established[2], but Angel and their siblings[3] were on a child in need plan at the time due to a history of domestic abuse, physical abuse and neglect.

2. This review will consider systems and practice within and between partner agencies in the South Tees area specifically regarding the assessment and safeguarding of children who have recently moved to the area and have additional needs, where the children have been the subject of child protection plans in the past, and where the parent's first language is not English.

3. The learning identified is in relation to:
    - All agencies need to recognise that children who live in the area are their full responsibility, even if they have just moved there.
    - The need for robust and timely information seeking and sharing when a family move into the area, without relying on a parent's self-reporting.
    - A requirement for improvements in practice when children on child in need plans move.
    - The need for curiosity and vigilance in identifying the impact of moves of home area on children.
    - Increased professional confidence in sensitively introducing the use of interpreting services when a family do not speak English as a first language and where there are potentially cultural differences that need to be explored and understood.
    - Consideration of the impact of a family coming from a minority culture on their engagement.

[1] The child's mother chose this name. She also requested that we use the English language version.
[2] The inquest is pending.
[3] The number and ages of the siblings are not disclosed due to concerns about this identifying the family.

Process

4. The review started with consideration of the detailed agency information provided for the CDOP[4] and rapid review processes, where clear lines of enquiry were identified. Further information was sought from the involved partner agencies including a request for reflection on the quality of involvement with the family, and the identification of single agency learning and improvement actions, if required.

5. An independent lead reviewer[5] was commissioned to work with a panel of local safeguarding professionals from the key agencies. The lead reviewer facilitated a face-to-face practitioner event, the aim of which was to consider the details of the professional involvement with the family and what learning professionals felt was apparent regarding professional practice and local systems. However due to staff leaving[6], sickness or not prioritising their attendance, only one professional who had direct involvement with the family at the time attended the event. Line managers and safeguarding leads attended to represent their agencies.

6. The lead reviewer has written this report and worked together with the panel to identifying the overall learning and agree recommendations from this CSPR.

7. The lead reviewer and a representative of the partnership met with Angel's mother, with the assistance of an interpreter, to inform her of the purpose of the review and explore if there was any additional learning from her perspective. The review panel extends its thanks to her for her reflection at a very difficult time. Meeting her reinforced the need for all professionals to recognise and acknowledge the impact of grief and loss on the families they are working with.

Family details

8. After their birth, Angel returned home to live with their single parent mother and several of their older siblings who have needs of their own. The family had not lived in their accommodation for long and there were issues with the substance of the building (such as broken doors and a need for extensive redecorating) and there were limited furnishings and home comforts. One of Angel's older siblings was living with foster carers elsewhere, and their mother found this difficult emotionally. The older siblings could be boisterous and demanding of their mother, who sometimes struggled to manage their behaviour. The care of Angel was said to be good with appropriate routines. They were breast fed and had a cot in their mother's room. The professionals involved at the time had an understanding of Angel's lived experience.

9. Both of Angel's parents were originally from an eastern European country and moved to the UK in around 2005, prior to having children. Although they had previously lived in Middlesbrough in around 2017, it appears they have moved around 53 times in the 14 years that they have been parents. Mother returned to Middlesbrough with all but one of her older children in 2021, having separated from the children's father. The children had been on a child protection plan and the subject of care proceedings in another area (to be referred to as Local Authority A) in 2019. The threshold for significant harm was met at the time as they were made the subject of interim care orders and then supervision orders. The family

[4] Child Death Overview Panel – a multi-agency function to review all child deaths in the area
[5] Nicki Pettitt is an experienced lead reviewer and has been undertaking serious case reviews and CSPRs since 2009. She is entirely independent of all partner agencies in South Tees.
[6] This reflected significant resource issues locally, with difficulties in recruiting permanently to key positions like social workers.

then made an unplanned move to another area (to be referred to as Local Authority B) without informing professionals in Local Authority A. They lived in Local Authority B for around a year before again moving to Middlesbrough in 2021.

10. One of the children remained in foster care in Local Authority A. A care order had been made due to their serious disabilities and a concern that the parents could not meet their significant special needs. Local Authority A remained involved with the older siblings despite them living in Local Authority B, as they were the subject of court ordered supervision orders, that Local Authority B refused to take responsibility for. CSC in Local Authority A closed the case when the orders expired in May 2021, and the children became the subject of child in need plans, and the responsibility of CSC Local Authority B.

11. The older children had experienced domestic abuse (with their father as the perpetrator) and physical abuse from both parents. There were neglect concerns, including neglect of their health needs, lack of supervision and a history of poor engagement with services. Father was known to be intimidating and abusive to professionals. He has long term issues with alcohol misuse and has been prosecuted for drunk driving with children in the car.

12. Just prior to the move to Middlesbrough the police were called to a domestic abuse incident in Local Authority B. Mother was physically assaulted by Father, and he made threats to kill her. The children were present. Mother told the police that Father had been violent to her for 14 years. They separated following this incident and Mother and the children moved to Middlesbrough without him.

13. Around 6 weeks after arriving in Middlesborough, Mother booked her pregnancy with the midwifery service, at 20 weeks gestation. The midwives made a referral to the Middlesbrough MACH[7] due to the family 'escaping domestic abuse.' A social work assessment was undertaken and child in need plans were made a month before Angel died.

Analysis and identification of learning

14. Through the detailed consideration of the professional involvement with Angel and their family, the review has established learning in the following areas:

Impact of multiple moves

15. The extent of the family's transience was not appreciated by any agency in South Tees prior to the death of Angel. They had moved multiple times within and between at least five different local authority areas in England. There was a resulting lack of information known in Middlesbrough about the children's history and lived experience. Those who met the family in the months following their move to Middlesbrough largely relied on the mother's self-report of their history and involvement with agencies. Those involved were shocked to learn of the extent of the family's transience during this review. They told the review that this was because of having limited time to seek and consider the case history, and difficulties in accessing information, particularly from other areas.

16. There was a view in Local Authority B that the difficulties in the past were due to domestic abuse and Father's alcohol misuse, and that the mother's separation from him reduced risk to the children. CSC in Local Authority B informed Middlesbrough of Mother's planned move to Middlesbrough with the children

[7] Multi-Agency Children's Hub - the front door to children's social care (CSC)

and that they were on child in need plans. They also shared that should they remain in Local Authority B it was likely that they would be stepped down to early help due to the parent's separation and because Father had left the country. The Middlesbrough MACH did not accept responsibility for the children at this time as they did not yet have an address in the area and because no written information was shared by Local Authority B CSC. Information shared by Local Authority B for this review states that 'multiple house moves have caused instability for the family and a start again scenario for services.' This review agrees.

17. When it was confirmed to CSC in Local Authority B that the family had actually moved to Middlesbrough there is no evidence that they informed Middlesbrough CSC. They appear to have simply closed the case. This can often happen when children are on a child in need plan. There are clear nationally agreed processes that need to be followed when a child on a child protection plan moves into a different local authority area. The same is not the case for children in need. The Children Act 1989 is clear that the responsibility for safeguarding and promoting the welfare of the child lies with the local authority where the child is to be found, so when the family gave up their property in Local Authority B and moved to Middlesbrough, the responsibility for them became Middlesbrough's. The Tees safeguarding procedures state that when a child in need moves, 'given the child has already been identified as having particular needs or is vulnerable in some way, urgent consideration / assessment should be given as to the impact of the move for the child in respect of their vulnerability'. They also state that 'all relevant information should be shared by the previous authority, including social work assessments, plans, minutes of the latest Child in Need Review and a summary / case report.'

18. As well as this, there are clear processes listed that would be good practice in a case of a child in need moving, including multi-agency information sharing, consideration of a joint social work visit and a handover Child in Need Meeting, so that the issues can be fully shared with all agencies[8]. This would require the consent of the parent. In the case of Angel's siblings, practice from both areas fell short of these expectations. The case was only opened for a social work assessment of all the children because of the new pregnancy, and it was then that the concerning issues for the older children became apparent and further requests were made for information from both previous Local Authorities. When reflecting on why there was a delay in considering if the children should be assessed and acknowledged as children in need, the review understands that this was in part due to the limited information accessed and available that provided a full overview of the family history, the reassurance of Father no longer being around and a general fatigue in the area in respect of the number of transient families moving to the area and the demand this creates for local services that are already stretched.

19. The review can see that the concerns included cognitive and developmental delay for at least one child, health issues for several the children, including high BMI, enuresis, vision difficulties, bow-legs due to vitamin deficiencies, anaemia and very poor dental care. These issues were exacerbated as there was a history of the children not being bought to health appointments. Very poor school attendance in the past, and clear young carer responsibilities for the older children were also apparent. During the review it was

[8] However, the Data Protection Act should never be a barrier to 'sharing information where the failure to do so would result in a child or vulnerable adult being placed at risk of harm' or indeed on those occasions where seeking consent might increase the risk of harm. (from Tees child protection procedures.)

reflected that community health professionals do not usually check the page on System1 which shows the addresses a child has lived at. It is good practice to do so, and it only takes one click to access the information. This is where the exceptionally high number of moves of address was identified during this review, which would have been helpful knowledge for those working with the children at the time.

20. The children's multiple moves resulted in drift and delay in accessing health assessments and interventions for the children's health needs. There were numerous failures to hand over ongoing health interventions over the years. The number of school moves also led to the children's education and social needs not being met. Despite this, the focus when the family were leaving Local Authority B was on the likely reduction of risk due to the father no longer living with the family, with little consideration of the evidence of long term and cumulative neglect and no clear understanding of Mother's role in this.

21. Because the children were effectively just receiving universal services when they arrived in Middlesbrough in 2021, the opportunity to ensure that they had timely health interventions was missed. The known and shared issue at the time was that the family were fleeing domestic abuse, rather than the reality of them being a family with a history of significant neglect that had moved extensively and not had any consistency of professional oversight and intervention. This false understanding had an impact on the response of services such as school nursing, who had been contacted by their equivalent in Local Authority B and were informed of the history of poor dental care. There is a shortage of NHS dentists in Middlesbrough, so the school nurse contacted Mother and offered support to find a dentist for the children. There was no information shared by the Local Authority B school nurse about the child protection plans and care proceedings in Local Authority A, the child in need plan in Local Authority B, the history of neglect of the children's health needs, and known concerns about management of the children's behaviour.

22. When the case was opened to CSC in Middlesbrough during the pregnancy with Angel, the social work assessment included two planned home visits and two unannounced. All of the children were spoken to, and the written assessment includes analysis on the children's lived experience and has used some of their words directly. Single agency learning has been identified about the need to ensure that during the period of assessment there can also be actions taken, for example making referrals for practical and emotional support for the mother and the children, which were needed.

23. There were discussions with the children's Middlesbrough schools but not the schools the children attended fairly recently in both previous areas. The midwifery service was also consulted, but not the health visiting service. CSC in both of the previous areas were contacted and specifically asked for copies of documents including chronologies, assessments and plans. These key documents were not forwarded. Local Authority A CSC just sent an email with a brief overview of their involvement in the case, focusing mostly on the child who remained in their care. Around a month after the request was made, Local Authority B CSC redirected the social worker in Middlesbrough to their information governance team for an access request to be made. In the circumstances, this was inappropriate, as there was a clear history of child protection concerns which required sharing in a timely way. This delay and lack of cooperation means that the extent of the children's concerning history was not known by the

social worker undertaking the assessment or the social worker who then took on responsibility for the child in need plans in Middlesbrough.

24. It is significant to acknowledge that the legal threshold for significant harm had been met in respect of all the older children when they lived in Local Authority A, and it is important that any new local authority has sight of the full chronology and court papers, as well as other multi-agency documents such as plans or records from child protection conferences. The social work assessment did result in all the children and the unborn baby being made the subject of a child in need plan, and a new social worker was allocated as the case moved teams. Mother said that while she understands that their moves and the systems in which social workers work lead to changes of worker, this has been hard for the family.

Provision of services and responses in Middlesbrough

25. Mother attended the Emergency Department with abdominal pain shortly after the move to Middlesbrough. She was 19 weeks gestation and told staff that she was due to go to London for a termination. A scan was completed, and Mother then decided to go ahead with the pregnancy. This means that Mother was 20 weeks pregnant when she saw community midwives to book in. Mother told the midwifery service that she had been ambivalent about the pregnancy and had been considering a termination. This information was not shared with the health visitor. There was also no information sharing from midwifery services about the appointments that Mother missed in the months that followed. It is good practice for health visitors to receive information such as this from their midwife colleagues as they will be providing longer term care to a mother and child post-natally. It is not considered a 'late booking' in local procedures prior to 24 weeks gestation, so there was no expectation that Mother's booking at 20 weeks would be referred on to any other agency or highlighted as a risky pregnancy. A referral was made to the Middlesbrough MACH due to the information shared by Mother in respect of domestic abuse and the involvement of social workers in the past, but it would be expected practice to also share referrals of this type with the health visitor.

26. It is good practice in Middlesbrough that health visitors visit families antenatally. This is not always happening in other areas of the UK due to capacity and issues with recruitment and retention of staff. It was clear to the health visitor allocated to unborn Angel that the family were likely to be vulnerable, even though they came through to the service as 'universal'. She was not initially aware of the history of CSC involvement, but made enquires and found out, from speaking to one of the older children's primary school in Local Authority A, that the children had been on a child protection plan for neglect. The health visitor stepped them up to the 'best start pathway' in order to provide an enhanced service. She had enquired about CSC involvement in both Local Authority B and Middlesbrough when the case was allocated to her, but on the day that she enquired both the Local Authority B MASH and Middlesbrough MACH informed her that there was no current social work involvement. The Middlesbrough MACH opened the case for an assessment just a few days later but did not contact the health visitor, who was therefore effectively working in a silo at the time. This lack of communication maybe because all the older siblings living with Mother were of school age and there could be a lack of understanding from social workers that health visitors are involved pre-birth. The opportunity should be taken to ensure that social workers are reminded that any pre-birth assessment needs to involve the health visitor allocated to the unborn child.

27. There is a general shortage of school places in Middlesbrough, and this appears to have had an impact on the family getting school places for all the children when they first returned. While places were available immediately for some of the children, there were particular issues with a child in year 2 and the eldest child, of secondary school age, getting a place. This resulted in them missing many months of education. It took over 6 months and an escalation by the social worker for the eldest child to be given a school place. This was due to a combination of issues at the preferred choice of school that the Local Authority are aware of, and the review was told that the school has been supported to ensure that the admission process has improved. Unfortunately, none of the schools attended by the older children in the family attended the practitioner's event held as part of this review, and a recommendation has been made for the Partnership in respect of the need for schools to be more involved in their work, as this has been acknowledged as a wider issue.

28. There were several other gaps in the children's schooling prior to the latest move, including during the pandemic where the family chose not to take up the offer of continued school attendance due to the children being on a child protection plan at the time. Schools had no authority to insist that children attended at the time. This case also reflected the wider issue both locally and nationally of school records not always following children who move in a timely way. The expected timeframe for pupil records to be transferred to the receiving school is five days. For any child, the lack of records is concerning, but for children with a history of safeguarding concerns and on-going challenges, robust practice is required, both from the school the children are leaving and from the receiving school in chasing records. The Middlesbrough school had no record on their system of how many and which schools the children had attended previously, so were unaware of both the level of disruption to their education or whether there were safeguarding concerns at the previous schools. The review reflected that practice needs to be improved to enable better communication about children with their previous schools, an understanding of the need for schools to consider the impact on a child's education and wellbeing of multiple changes, and a need to challenge the apparent acceptance of children changing schools.

29. When the children were being cared for by extended family members at the time of Mother's confinement, one of the older children was injured and there was a possibility that the injury was inflicted by a relative. A section 47 investigation was completed, and no further action was taken, although it was made clear to the children's mother that the family member should not have care of the children again. The strategy meeting that considered this potential non-accidental injury led to an improvement in the multi-agency knowledge of the family history, although gaps remained. The alleged incident led to Mother receiving less support from her family after the birth of the baby, however. The child in need plans were ongoing however and there is evidence that the allocated social worker in the long-term team (who was allocated after the assessment agreed that child in need plans were required) worked hard to provide practical assistance with furniture and school places, along with monitoring the home conditions and supporting Mother to make the required improvements.

Working with families with language and cultural differences

30. The review was told that the children's mother didn't always acknowledge at the time that her spoken English could limit her understanding of what professionals were saying. This is understandable and

common and needs to be handled sensitively by professionals[9]. Despite what the service user says, they need to remain open minded to whether the service user's understanding is sufficient for the discussions that are required and revisit the need for interpreters regularly. When meeting with Mother as part of the review, it was clear that while her understanding of spoken English appears to be good, it is not always clear what she is saying. She told the lead reviewer that she gets frustrated when trying to communicate in English, and she clearly made good use of the interpreter. She agreed with the finding of this review that professionals need to be honest about whether an interpreter is required for them to understand what a service user has to say.

31. The health visitor was able to establish immediately that an interpreting service was required, and this was accepted by Mother and used on every visit. However, the midwives and CSC did not use an interpreting service and told the review that Mother had been 'offended' by the suggestion. This is something that they explained can often be an issue. In this case the lack of interpreting support would have limited their ability to communicate effectively with Mother and undoubtedly had an impact on gaining a full understanding of the family history and current situation. The children spoke good English and were occasionally used to clarify things with their mother, which, while common, is of concern. Good quality telephone interpreting services are reportedly available to staff and need to be promoted, but also professionals need confidence in how to approach this issue with families in a sensitive way.

32. The review was told that the health visiting service was doing a lot of core contact by phone at the time. While this might be suitable in some cases, it makes the use of an interpreting service very difficult. This is part of the reason that the health visitor in this case wanted to visit Mother face to face both before and after the birth of Angel, which is good practice. She also spoke of the need to be clear with families where there are cultural differences about expectations in the UK, for example regarding the need to use car seats, and about the need for and the provision of free antenatal care. There is also the possibility that parent's who grew up elsewhere may be confused and concerned about professional engagement in their family, and this also requires skilled and sensitive handling. The national panel's latest annual report on CSPRs was published in December 2022[10]. It states that 'poor parental engagement by minoritised parents has been linked with fear, including fear of the power professionals wield', and that 'professionals need to recognise, explore and seek to allay such fear while working with the parents.' Mother confirmed that she was extremely concerned that her children would be taken away. She can now recognise that she requires support and would want to reassure others of the need to accept help without fear.

33. Mother and the children had been the victims of violence in their home from the children's father. Although the relationship was over, there was a need to address this with the family, for all of them to have insight into the impact of living with domestic abuse. This was needed to prevent reconciliation with the father or future abusive relationships for the mother, and a referral was made for her to attend My Sister's Place.[11] There was also a need for preventative work to be undertaken with the children, as those who experience domestic abuse as children are more likely to be in an abusive relationship

[9] This may also be relevant when there are other issues that may have an impact on understanding.

[10] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1123918/Annual_review_of_local_child_safeguarding_practice_reviews.pdf

[11] A local independent specialist 'One Stop Shop' for women aged 16 or over and have experienced or are experiencing domestic violence

themselves as adults, along with consideration of their therapeutic needs because of the trauma and cumulative neglect they have experienced over time.

Conclusion and recommendations

34. This CSPR was initially commissioned because of the possibility that the death of Angel was not accidental, due to comments made by her mother at the time of the child's death. This is awaiting resolution. While the criteria for a CSPR may not have been entirely met, it has been a useful process to identify learning, particularly about safeguarding children who move within and between areas.

35. The national CSPR Panel report 2022 states that the findings of Local CSPRs need to be contextualised with other reports, inspections and audits, to get a broader understanding of practice and organisational challenges. Similar issues have been found in cases considered at the CDOP[12] in the region regarding apparent barriers to the use of interpreters, which is being considered. There is a newly formed Tees-wide partnership Task and Finish Group being set up in respect of transient families, that will use the learning from this review to consider improvements. There are several cases that the Partnership are aware of where the families have moved between local authorities within the region, and learning from these cases validates the findings and recommendations of this CSPR.

36. The review has found the need for improvements to be made which will make a difference to the children of Middlesbrough, particularly those who have moved here from another area. The message that these children need to be recognised and owned locally is an important one. The review has therefore made the following recommendations for the STSCP:

Recommendation 1: That the STSCP shares this report with the Safeguarding Children Partnerships in Local Authority A and B with a request that they reflect on the concerning findings and the learning identified regarding the seeking and sharing of information when children move into and out of their area.

Recommendation 2: The STSCP must reinforce that children with a safeguarding history who move area are potentially some of the most vulnerable children. They must ask partner agencies to provide assurance of good practice (including information seeking and sharing) and robust and consistent systems that acknowledge local ownership and meet the needs of these children.

Recommendation 3: The Partnership asks all agencies to:

- Remind all professionals about the value and importance of using interpreting[13] services, including provision of the cultural awareness required to work in a meaningful way with the family.
- Ensure they support professionals with how they sensitively introduce the need to use these services with families.[14]

Recommendation 4: The STSCP asks partner agencies to promote that a health visitor must be involved in assessments and planning for unborn children.

Recommendation 5: The STSCP to ensure that the schools in this case and more generally are engaged effectively in CSPR and learning processes.

[12] Child death panel
[13] This should include that interpreters are valuable in providing cultural understanding
[14] As the health visitor did in this case