South Tees Safeguarding Children Partnership

Child Safeguarding Practice Review

AIDEN

Report Independent Author & Lead Reviewer

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March 2025

Local Child Safeguarding Practice Review

Child Aiden

Contents

Report Independent Author & Lead Reviewer Suzy Kitching[1] MBE.

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1: Introduction and summary of learning

1.1 South Tees Safeguarding Children Partnership commissioned this Local Child Safeguarding Practice Review (LCSPR) to consider systems and practice within and between partner agencies regarding the multi-agency responses following the death of a 16-year-old child by hanging. There were no indications of any third-party involvement. Child Aiden will be used to protect the young person's identity. The death by suicide of a child is tragic and traumatic for families, communities, and professionals to understand and process. By exploring Aiden's lived experiences and the services and systems that supported him can help the Partnership reflect and learn about what helped and what could be improved when working with children and families in similar circumstances.

1.2 Over 200 teenagers are lost to suicide each year[2] with suicide being the main cause of death in young people under 35; the majority were boys or young men. With the rising mental health needs of young people and children, this is a significant public health issue[3] and this is reflected in the National Suicide Prevention Strategy (2003) and locally in the Tees Suicide Prevention Strategic Plan 2024- 2029. There has been work completed to evaluate a marked increase in young people's deaths across Tees in 2024, and whilst there has been no identified link or pattern, this has strengthened the partnership work to support children and young people, making the findings of this review helpful.

1.3The family were involved with universal[4] Services and Learning Disability (LD) CAMHS at the time of the significant incident. There had been periods of intervention and support at Early Help, CIN, and Threshold for Child Protection. (Section 47 investigations). There are no parallel processes that could impact this review.

1.4 Summary learning.

The following learning points are detailed in the report and summarised here.

1. Strengthened understanding of children's lived experiences in the context of any additional learning and neurodiversity factors, their developmental stage, and what children need from their parents to help them thrive.
2. Increased curiosity about the significance of predisposing vulnerabilities, parental history and capacity, situational factors, and how they intersect in all multi-agency assessments.
3. Developed knowledge and skills regarding the impact of parental mental health difficulties on the care of children and family functioning.
4. Threshold decisions for neglect should always be considered in the context of cumulative harm, adversity, vulnerabilities, and parental capacity. Decision-making to close or step down a case must involve all the professionals involved with the child and the family.
5. Improved understanding of cross-boundary processes, roles, and responsibilities when transferring cases.
6. Increased knowledge about homelessness duties.
7. Ensure fathers are included and their needs and their role are understood.
8. Improved understanding and support to embed critical thinking and professional challenge processes and outcomes.

[2] Latest statistics | Papyrus
[3] The Big Mental Health Report - Mind
[4] Universal services are services provided to all children and their families regardless of their needs or circumstances, for example, health visitors, GP's schools and leisure and community services.

9. Strengthened knowledge and support for practitioners and managers in relation to self-harm and suicide. This must include safety planning for children with suicidal ideation and must be shared with the family and wider professional network and regularly updated.
10. Information sharing and seeking between CAMHS and the professional network must be routinely undertaken by CAHMS and consistently updated to support young people's needs, well-being, and safety.

2: The review methodology

2.1 The Learning and Development Group's Case Review Panel agreed on the methodology and Terms of Reference for the review and has provided oversight and quality assurance. The Rapid Review identified initial learning and key lines of enquiry with feedback from the Child Safeguarding Practice Review Panel. Areas for learning included risk assessment, thresholds, and triggers for suicide in young people, the partnership's response to cumulative neglect, step-down procedures, working with schools, and understanding the impact of parental mental health and the role of men/fathers.

2.2 The review process was reflective and proportionate, involving practitioners and strategic managers at two reflective learning events. It has also included professional discussions to explore specific areas of enquiry over homelessness, the SEND processes, and discussions about the broader context of death by suicide across the locality. The reviewer appreciates the time professionals have given to this.

2.3 The following practice themes were identified and formed a framework to analyse the findings, inquire, and develop an understanding of what was happening and what it meant in the circumstances for Child Aiden. These are not necessarily considered chronologically but takes a thematic perspective. It also identified an additional area of enquiry to consider: the family's cultural identity. The learning events have directly informed this report and supported wider learning and single agency learning and improvements. The reviewer is appreciative of the discussions at these reflective sessions, recognising that the loss of a young person can be hugely emotional for everyone involved.

Thematic focus
1. The children's lived experiences and needs. Cumulative neglect and its impact.
2. Multi-agency working. Thresholds and decision making.
3. Recognising and responding to suicidal ideation
4. Unconsidered men
5. Cultural considerations

2.4 Exploration of unconsidered men and cultural considerations are discussed within the three overarching themes to avoid repetition and because of the minimal known information. After speaking to mother, she shared that she and the children identified as (non-practising) catholic and shared that Aiden like to see himself as a little bit different, but the family were not part of the travelling community.

3: Family views

3.1 Family views are important and integral to LCSPRs. Invitations were sent to inform both parents about the review process, followed by an offer to meet with the parents and their elder siblings at different stages of the review. This was also followed up with services directly involved with the family to ensure sensitivity and support. This offer remained open throughout the review process. Mother came forward late in the review process, and the reviewer is appreciative that she felt able to do this. The offer was made to meet with the father, but the mother reported that he was not in a position to talk about matters, and she spoke for the family. The reviewer met with mother and the STSCP business manager. The review process, findings and learning were shared, and an overall summary of the findings from the review was shared at that stage. Subsequently, the report has been shared with the mother by the partnership, and the author and partnership have been in dialogue with mother. There remains a significant difference in the views of mother and the professionals regarding help provided to Aiden and the family. The reviewer appreciates her candour and acknowledges the difficulty of this learning process from the family's perspective. Factual amendments have been made to the report respecting mother's views, and key points of difference are included below and added to the report where possible. The family is being supported by services, which will hopefully strengthen and support relationships.

3.2 Mother shared a positive relationship with her son, who was loving and a loved member of the family. Mother is a passionate advocate for her son and shared at the end of our meeting a support group in relation to mental health and neurodiversity established to honour her son and support other young people and families. This is a positive initiative, and we discussed how this could help shape training and guidance for the partnership about understanding and living with children who express self-help and suicidal thoughts.

3.3 Mother shared a lack of trust in the professionals involved with Aiden and felt "let down" by services that were there to support her and her son. This was a strongly held view, and she believed that professionals involved in the review process will have misrepresented her views. Mother disagrees with professionals' views that they struggled to engage with the family.

3.4 There appeared to be three main areas of dissatisfaction that focussed on the school, the housing authorities and CAMHS. She was positive about the help and support she had received from early help in Local Authority 2. However, her views about the same areas of social work support were negative; she shared that she felt judged particularly about her mental health difficulties, which she did not agree with. Her views also reflected the findings in the review about the number of staff changes at the time.

3.5 Mother did not accept that the school had provided a good level of support and care for Aiden, nor did she have a positive relationship with them. She did not agree that the school had an established relationship with Aiden. She felt they were not meeting his needs and did not know how to manage his behaviours, believing their approach directly affected his attendance, i.e., they challenged him negatively and, as a result of his behaviours, regularly suspended him. She reported he was unhappy about going to school. She did not accept that he was anxious about his exams, and this contributed to his anxiety. She felt unsupported by his school over the request for a school transfer. She did accept it was proving difficult when working with the SEND officer to find a school that could meet his needs in Local Authority 2. When asked what she felt the school could have done differently, she stated they saw him as a naughty boy and should have kept him in school, and they did not provide him with the help and support he needed. The understanding of the processes to the right, which support his EHCP, mirrored the learning from the review, and in particular, the cross-boundary barriers identified in the review.

3.6 With regards to Aiden's mental health mum was reflective and recognised that she had lived with his mental health difficulties over time and wondered if she had 'normalised' his behaviours. Despite this, she recognised that his mental health was deteriorating. She reported he was year 11, and it was a time when he was receiving more and more school

suspensions due to his behaviour. Due to her worries, she took Aiden to see the GP, who referred him to CAMHS. The mother shared some contradictory views about the support her son received from CAHMS; she did recognise that he did seem to get something from the sessions, and the staff had the skills to engage him and work with him in both clinical and home settings.

3.7 Mother makes some important points about communication and understanding of the service that need further exploration and discussion from CAMHS. (REC)

- Late letters, sometimes sent the day before his appointment, made it difficult to keep appointments and then led to feelings of being blamed for non-attendance.
- 'Discharged' from his therapy provision, although explained in a home visit, mother struggled to understand why this service took him on if it was not the correct one. It is a concern that no alternative provision was identified.
- Aiden's safety plan was not shared with his family, which is a recommendation of the review.

The mother shared what could be helpful for other parents /carers in relation to accessing mental health support for young people by helping them understand the process and provide guidance. CAMHS and STSCP should listen to the views of parents /carers to strengthen service and practice improvements. REC

3.8 Mother expressed her frustration with the housing process, describing poor communication, an unwillingness on the part of either the housing authority to take responsibility, and a lack of understanding about the process. This meant for the family the continual threat of homelessness. This is reflected in the findings and learning from the review and shared with mother. Mother shared that what could be helpful to other families was clear information and guidance shared face-to-face about the process.

3.2 Child and Family overview

3.2.1 Aiden was the second-oldest child in a large family; he was cared for at home by both parents. The family previously lived in Local Authority Area 1[5] and moved to Local Authority Area 2 following a violent attack involving weapons. The family's ethnicity was not identified, and there is minimal or no information available about this; consequently, the family's culture and identity are largely unconsidered. This is a significant omission that could have contributed to a greater appreciation of the family's needs, behaviours, and responses.

3.2.2 Aiden was seen by CAMHS as early as six years old, and there were worries about his behaviour at school and home. This included poor attention, difficulties in sleeping, increasing aggression and violence towards family members. He was assessed as having a moderate learning disability. His needs were assessed, and he received an Education, Health, and Care Plan (EHCP). [6] By the age of eleven, concerns included self-harm behaviours and thoughts that expressed suicidal ideation.

3.2.3 He was assessed for Autism [7] and formally diagnosed; he was sometimes referred to as having Asperger Syndrome, although this term is no longer used as a diagnosis.

3.2.4 Home conditions were repeatedly seen as poor and neglectful by professionals involved with the family with issues over increasing financial difficulties, overcrowding, the children being unkempt, and not consistently brought for health and development appointments. Some of the children in the family displayed behavioural issues, and there was physical health needs associated with neglect. Health visiting professionals consistently highlighted concerns about cumulative

[5] Local Authority 1 is where Aiden and his family lived before moving. Local Authority 2 is the current area where the incident occurred.
[6] A formal legal plan that sets out a child's educational, health and social needs and the support to meet those needs
[7] What is autism? - NHS

neglect, and there were difficulties at different times in engaging with the family and having access to the children. Mother strongly disputes issues of neglect; while discussed with mother by the reviewer, this will need further discussion by professionals involved with the family. Professionals at the learning event referred to the children as '***being guarded.'***

3.2.5 Mother experienced long-standing mental health problems; positively she sought support from her GP and her Community Psychiatric Nurse at various times. (CPN). Professionals reported that the mother did not always acknowledge she had any mental health difficulties. Mother's mental health and its impact on her capacity to parent safely led to a referral to Local Authority Area 1 MACH. (see timeline). Further concerns were reported by health professionals around the birth of the new baby and the mother's engagement with her CPN and managing her medication.

3.2.6 Information about father is silent and unconsidered regarding most services' involvement. There were indications that father was involved in criminality and associated with drugs. There were investigations following concerns about criminal activity and then an incident that led to safeguarding concerns and a move for the family. Within six months of this, father was arrested for possession of Class A drugs and later arrested for drug driving. There is no information known or explored about possible drug use.

3.2.7 The family's reported history shows insular characteristics with strong family relationships; there is minimal information about wider family and community support. The family accessed universal services and targeted children's services (CAMHS) for Aiden, and mother accessed support and intervention from community mental health services. There were periods of early help, child in need, and three brief periods of child protection investigation across Aiden's life. Threshold decisions were mirrored across the two local authorities that form the safeguarding partnership footprint.

3.2.8 Contacts and referrals regarding the family involved persistent and long-standing worries about Aiden behaviour and emotional well-being, additional needs, and mother's mental health. There were continued concerns about neglect, including overcrowding, poor home conditions, financial difficulties , neglectful physical care, not being brought for health appointments, school attendance and paternal criminal activities, including a threat on the family. A key thread is the difficulties of some professionals and the agencies they represented in engaging with the family.

3.2.9 A key practice episode covers the four months leading up to Aiden's death. (see timeline) This period featured increasing withdrawal from Aiden, particularly in education and disputes over his school choice. Mother's reasons for this were reportedly the increased stress the exams put on Aiden. Mother shared a different view in discussion with the reviewer.(See 3.5) The school was proactive in ensuring they stayed connected with Aiden at home during this brief period despite challenges from the mother; this is good practice from the school, recognising the increased risk non-engagement can pose for vulnerable learners. Once re-engaged back with education services, he shared increased anxiety and thoughts of harm to himself and others. Whilst he initially engaged well with CAMHS and completed safety planning about self-harm, there was inconsistency in accessing this support. Children's Social Care closed the case, identifying housing as the key issue, and stepped the family down to early help level 3 Stronger Families.[8]

[8] Tees-Framework-of-Need-Mar24.pdf

3.2.10 The threshold for support between partners at early help was also disputed. The outcome was that CAMHS took the lead for Aiden's support, and the primary school was the lead professional for the family at early help level 2. Professionals from the school remained unhappy with this decision and challenged it. It is not clear how any escalation progressed.

3.2.11 In the period before he died, Aidan's school and CAMHS made contact to see Aiden, engage parents and encourage Aiden back with services.

3.2.12 Aidan tragically took his own life at home; it is not known accurately when this occurred; his parents reported no specific concerns seeing him late in the evening and shared it was not unusual for him to spend all day in bed.

3.2.13 A high-level Timeline has been developed to support analysis; this has been used to support key episodes where both practice and systems have interacted and enable longitudinal analysis of some key events and circumstances across Aiden's life. Using a systems methodology review such as the Pathways to Harm and Pathways to Protection (Brandon, Sidebotham et al)[9] enabled evaluation and discussion at the learning events to consider how services, practitioners and family responded to his needs and increased stress and anxiety.

[9] Figure 2 Pathways to harm, pathways to protection
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/869586/TRIENNIAL_SCR_REPORT_2014_to_2017.pdf

Timeline Aiden

South Tees Safeguarding Children Partnership

Age 0-11
Early difficulties in managing emotions. Understanding neglect

- Living in Local Authority 1 with both parents. Five siblings.
- Aged six referred to CAMHS. Concerns regarding behaviour, poor attention, and lack of sleep. Increasing aggression and violence toward family members. Borderline LD [1]. EHCP initiated.
- EHA [2] completed. Indicators of Neglect. WNB. [3]
- Paternal issues with alcohol and criminality.
- Stepped up [4] to social care regarding Neglect. Active for 12 months, closed due to improvements.
- CAMHS reports he likes feeling pain and has been self-harming. Sleep and anger issues
- Reports of self-harm and low self-esteem from school and expresses suicidal ideation. Aiden reported to drink bleach. Stated, '*he didn't want to be here anymore.*'

Age 12-13
Maternal mental health worries. Diagnosis for Aiden

- Concerns about mother's mental health deterioration. Early help psychosis team involved.
- Children's social care referral progressed.
- Aiden admitted to hospital with headaches, confusion and unsteady on his feet. No obvious cause.
- WNB for follow-up.
- Diagnosed with Autistic Spectrum Disorder and Aspergers Syndrome.
- WNB health and CAMHS appointments.

Aged 14
Escalating situational risks and harm. Family move to Middlesbrough

- **Strategy meeting.** Reports that weapons in the home. Concerns about a lack of progression of CIN plan, WNB, parental mental health, overcrowding and neglectful home conditions. Worries about Aidens mental well-being and developmental vulnerability.
- Professionals struggle to see the children and engage the family.
- **ICPC held**. Aiden was struggling to manage emotions, twice tied a ligature to his bed and mismanagement of his ADHD medication. Threshold not met : to remain at CIN.
- **Strategy meeting** Reports of males with machetes and wearing balaclavas forced entry to the home. All children were present. Outcome CIN continued.
- Family moved to Local Authority 2 .
- Referral made to Local Authority 2 MACH [5] family temporarily housed in Local Authority 2 . Early help support offered.
- Family not accepted as homeless in Local Authority 2 . The primary residence is Local Authority 1 and assessed as safe to return. Family remain in Local Authority 2 , continuing dispute over homelessness responsibility and parental actions.
- Father arrested for possession of Class A drugs. NFA. Father arrested for drug driving.
- Mothers pregnancy confirmed.
- Family 'stepped up' [4] to children's social care due to risk of homelessness.

Aged 15
Increased concerns about cumulative harm and Aiden's emotional wellbeing

- New baby born.
- School attendance deteriorating.
- Mother reporting homelessness, ongoing dispute. Assessed as intentionally homeless by Local Authority 1.
- School report Aiden saying he '*wanted to go to bed and never wake up*'
- Mother withdrew consent to CIN support. Case closed. Professional challenge led to referrals to MACH; threshold not met.
- GP shared concerns with health visitor about mother's mental health.
- Referral to MACH Cumulative concerns accepted. CIN assessment.
- Aiden receives school suspensions. Mother requests a school transfer to Local Authority 2 School. Review of his EHC Plan. Attendance dropped significantly.
- Aiden, seen by GP, reported anxiety and low mood says to mum wants to hurt himself. Advice and referral to CAMHS.
- CAMHS Triage: referred to LD CAMHS. Concerns include paranoia, perceptual abnormalities, and preoccupations. Struggling with negative feelings, poor sleep, isolation, challenging behaviours, and self-harm thoughts daily but no intention to act.
- LD Psychiatrist Assessment. No mental health diagnosis. Support via LD CAMHS.
- **Strategy meeting.** Aiden reported he tries to suffocate people in his sleep and 'he's weird'. Concerns about mother's mental health and poor home conditions.
- Threat of eviction remains.
- **ICPC Outcome Threshold not met CIN support to continue.**

Aged 16
Aiden's needs lose focus in wider context of professional and family challenges

- Engaging in psychological interventions. Safety plan completed with Aiden. Ongoing thoughts to harm self and others.
- His school move was declined. The requested school could not meet his needs.
- Graded Care Profile (neglect) assessment commenced. Social Care assessment concluded. Mother stable and Aiden supported by LD CAMHS. Focus was housing need.
- **Case stepped down to Early Help.** Not accepted at level 3. [6] School to be Lead Practitioner at Level 2. Aiden supported by LD CAMHS. Professional challenge made, not upheld.
- Local Authority 2 Homeless duty update, end of interim accommodation request.
- Aiden shares suicidal feelings and thoughts of hitting his mum.
- Further suspension due to behaviour. Mother notified the school saying the stress was too much for him.
- Parents disengaging with psychology appointments for Aiden.
- On the night before his death, no specific concerns were noted. Aiden could spend the whole day in his bedroom. He had barricaded the bedroom door and taken his life by hanging.

1 Learning disability
2 Early Help Assessment
3 Was not brought
4 Home - Tees Safeguarding Children Partnerships' Procedures
5 Multi-Agency Children's Hub
6 Threshold Document - Continuum of Help and Support

4.1 Aiden's lived experiences.

What was it like to be a child in this family?

4.1.1 This section explores the importance of understanding what life was like for Aiden and his siblings and what professionals understood about his lived experiences. It will consider how neglect is understood across the partnership in responding to neglectful care and the impact on Aiden, his additional needs, and his siblings within the same household. There are interrelated learning concerning thresholds explored in section 4.2 and learning from case reviews where cumulative adversity and neglect were not viewed as an associated risk factor where self-harm and suicide were identified. [10] (section 2.4).

4.1.2 Education and health visiting services made great efforts to identify Aiden and his younger siblings' needs, provide help and support, and significantly identified when care was being compromised. Aiden's needs were identified from an early age; at six, he was referred to the Community paediatrician and CAMHS. Mother shared with professionals that since the age of two she had problems with his behaviours. He was assessed as having a learning disability and received an Education Health Care Plan to meet his needs. Further assessment in early adolescence saw a diagnosis of Autism This meant that Aiden struggled to communicate and interact with his peers and adults, take on new information, and appreciate how others think and feel. He would likely become overwhelmed and anxious by unfamiliar situations and new events. It was noted he would use repetitive behaviours to manage some situations or resort to angry outbursts. His learning disability would have compounded his difficulties. Living in a large, disordered family, we know, caused him stress, and whilst his family tried to accommodate some of his needs, it can be seen that family life and events would have been hard for him to navigate on occasions. Whilst it is positive that mother sought help and support with Aiden, parental issues and needs and the home situation impacted the care he was given and significantly needed. Furthermore, his parents did not bring him consistently to health and education appointments, meaning his needs were not fully considered, this was a continuing pattern, why this was happening was not explored.

4.1.3 Of note is that Aiden had a learning disability and autism, which meant he experienced difficulties in learning and understanding things, developing new skills, processing complex information, and communicating. He could struggle with expressing his emotions and feelings. Aiden received a psychiatric assessment at age 15. Whilst there was no mental health diagnosis, it found some evidence of suicidal thinking, poor impulse control, and evidence of aggression towards others. Triggers for him were reported to be the current living arrangements. He did, however, experience mental health worries, and there is evidence to show that 70-80% of autistic children also experience mental health problems.[11] Aiden communicated with professionals through his behaviour and shared his unhappiness, frustrations, isolation, feelings of low self-worth, and anxiety. These are highly likely to have contributed to his feelings and thoughts of self-harm. (see timeline) Aiden shared his worries and anxieties with his parents, school and CAMHS and his behaviours were known.

4.1.4 Aiden shared his feelings and *'not wanting to be here anymore.'* repeatedly with professionals who heard this. (see timeline) He struggled to regulate his emotions and had aggressive outbursts with his family and the school community. He experimented with drugs and alcohol. The consequences of these behaviours were school suspensions, which in turn led to increased isolation. Significant attempts from the school, who provided some enduring relationships when he moved local authority areas, were made to work with the family and to engage him in education. Whilst Aiden's voice was recorded and heard from school and CAMHS, there was a limited sense of understanding of what this meant

[10] suicide-learning-from-case-review-briefing.pdf
[11] Mental health in young autistic people

for him and, importantly, connecting this with his lived experiences and what was happening within the family holistically. Behaviour must be seen as a form of communication[12] and may be linked to possible harm, trauma and neglect he may be experiencing. This increased his vulnerability and demonstrated the inconsistency of his home life and the expectations of him in more structured settings such as school.

4.1.5 Health visitors involved with the younger children in the family identified the cumulative neglect the children were experiencing and provided concrete examples of neglectful parenting. Aiden and his siblings were exposed to a range

"It is important for practitioners to build a trusting and respectful relationship with the child, which goes beyond listening and recording the child's views, to critically reflect on what the child is trying to communicate through their behaviour, interaction with others and physical presentation."

Understanding what the child's daily life is like. Key learning from case reviews

of long-standing co-existing adult issues around parental mental health, adversity, trauma, criminal activities, poor home conditions, worries of homelessness, unkept presentation, financial difficulties, and poverty. Studies show that historical and current themes in cases of neglect are complex and often include "*a multiplicity of factors – such as social and economic deprivation combined with parental difficulties"* Parental issues and Aiden's additional needs combined to create complexity. Financial and housing difficulties were a consistent feature in the family, and whilst practical support and guidance were provided, they were not directly seen as indicators of neglect. Studies show that poverty and inequality are key drivers of harm to children. (Bywaters, P)[13] These factors increased vulnerabilities for this family but were not considered in the wider context of the family's needs and functioning.

4.1.6 Mother's mental health difficulties are featured throughout the family's history. There were a number of diagnoses that were exacerbated by contextual stress factors. It is important to recognise that many parents who experience mental ill health can and do care for their children satisfactorily. Assessing the impact of adult mental health on parenting and family functioning is complex.[14] and studies show it is the *family disruption* that the mental ill health causes that presents the greatest risk. Duncan and Reader[15] talk about availability and predictability when considering the impact of mental ill health on children. Aiden needed a level of care and an environment that could respond to his emotional needs. Whilst his mother did respond appropriately to his mental health difficulties and seek help, there was an inconsistent response to the support put in place. Why this was happening was not fully considered such as the complexity of the home circumstances and the impact on care giving and how they could be overwhelming.

4.1.7 There is limited information to show that father may also have experienced mental health worries. He opened up to professionals about his own mental health, loss and lived experiences and having no one to talk to. He shared his isolation from his own family and that he was worried about his partner's mental health, and he did not feel listened to Father was given appropriate advice to see his GP, where assessment and support could be considered. This was a key moment for engagement with father, but it remained a singular instance and not fully appreciated within the wider context of the family's situation or history.

[12] The_Child_Safeguarding_Annual_Report_2020.pdf (publishing.service.gov.uk)
[13] Bywaters, P Skinner, G 2021 The relationship between poverty and child abuse and neglect. Nuffield
[14] Murphy M Rogers, M 2019) Working with Adult -orientated issues.
[15] Duncan , Reder (2003)How do Mental health problems affect parenting.

4.1.8 It is noteworthy that at a time of known increasing stresses for the parents, there was a sharp deterioration in the mother's mental health and an increase in difficulties with Aiden's behaviour at school and mental well-being (see timeline); significantly, the family withdrew their consent to Child in Need support. As a result of this, the family was closed to children's social care. This does not show appropriate critical thinking and exploration about ***why*** and, therefore, understanding the consequences and likely impact on Aiden and the family.

4.1.9 Information not fully known or explored at the time shows a limited understanding of the family's culture and identity. The significance of this for Aiden's lived experiences is therefore not known. It is important, therefore, that the adverse childhood experiences by Aiden and his siblings are seen in the wider contact of childhood vulnerability and ecological factors that increase the risk of child harm and poor developmental outcomes. [16]

4.1.10 Aiden spoke enthusiastically to the School and CAMHS about his love of and participation in Boxing, an activity the family supported, particularly his father. He was good at this, significantly supporting his confidence and feelings of self-worth. Knowing this, his school managed his alternative educational provision around gym times in an attempt to engage him. It also provided some structure and boundaries in contrast to his reported experiences at home. The review has highlighted that CAMHS recorded their engagement with father on home visits and around appointments for Aiden; it also showed that Aiden talked positively about his father and that this would have been an opening for professionals to engage with father, explore his role within the family and his role in parenting Aiden a narrative not known elsewhere in work with the family. Information sharing from CAMHS is a feature and is discussed later in the report.

Why does it matter?

Reflecting on the findings here enables an understanding of what life was like for Aiden, thereby appreciating his needs in the context of the family, culture, behaviours, and parental capacity. To ensure we assess and appreciate the circumstances of children and understand individual strengths, resilience, and vulnerabilities, we also need to identify **why** children's needs may not always be met and, therefore, consider ***why*** parents/ carers may behave as they do. This means understanding the lived experiences of parents /carers and thinking about what they need to help their children thrive. It means appreciating the impact of harmful behaviours and contextual societal factors such as family culture, social norms and community networks, the family's physical environment, and economic factors. The triangulation of this information should form the basis for a comprehensive multi-agency assessment.

Appreciating what it was like to be a child in this family. Aiden's needs were identified and known from an early age, and he received support from school and CAMHS. Links between his lived experience, neglectful care, and vulnerability to harm are highly likely to have impacted his capacity to feel safe and, therefore, contributed to his feelings of anxiety. There is no analysis of any work with Aiden and the family, and any involvement does not appear to be informed by past behaviours, outcomes, or measures of success. His diagnosis from an early age should have raised curiosity about this. The combination of his learning disability and ASD increased his vulnerability to harm, as evidenced by research and highlighted in the STSCP Neglect strategy.[17] His lived experiences were accumulative and neglectful, adding to his worries about daily living and functioning. *"The impact of neglect is not only widespread, affecting a wide range of developmental domains, it is also cumulative."* Cumulative neglect is also the "*most likely form of maltreatment*

[16] Early Intervention Foundation (EIF) February 2020 What we know, what we don't know and what should happen next diagram developed for Belsky et al. page 56.
[17] South-Tees-neglect-strategy-2024-2027.pdf

for a child to experience."[18] The impact of these neglectful home conditions, care, adversity and harm on his emotions and behaviour can be seen as he develops. (Timeline) It is critical that sufficient focus is given to the impact of the child's lived experiences, how this has been and is being addressed, and the behavioural responses to this harm. A child's behaviour must not be seen in isolation.

Appreciating mother's mental health issues. Learning from case reviews where parental mental health difficulties featured highlights a lack of understanding about the issues and meant that professionals did not always fully understand the potential harm to a child, the children's needs or identify support networks. It is recognised that assessing parenting capacity is complex and features changeable parenting relating to mental health episodes. Duncan and Reder[19] highlight the dilemma when assessing parenting capacity: "The question is whether the periods of good parenting can compensate for the episodes of adverse care and so help the child to tolerate them and make progress in all aspects of their development." It was important, therefore, to know if anyone else could support and meet the children's needs. There was insufficient understanding or assessment of father or any wider family and community network to be assured of this. Working Together 2023[20] Chapter 1 clearly shows the shared responsibility of a child-centred approach within a whole family focus. This approach "*sits within a whole family culture in which the needs of all members of the family are explored as individuals and how their needs impact on one another."* Understanding parents' issues and their impact on children can be understood as the interrelationship between "Preoccupation*, Availability and Ability."*[21]

Predisposing vulnerabilities, risks, and situational factors and how they intersect Being curious and exploring parental history, culture, and difficulties is critical to understanding parental capacity, risk, and safety and how they interact to balance vulnerability and safety. In this instance, they include culture and identity, neurodiversity, maternal mental health difficulties, neglect, and family functioning, including housing needs. The current discussion about ACEs [22] supports our understanding of the evidence base and informs strategies for systems and practice (trauma-informed approaches). This is important because it is known that Adverse Childhood Experiences (ACEs) can contribute to poor outcomes and have a *"devastating impact on children's physical health, mental health, and social well-being across their life course."* [23] . In simple terms, these experiences are likely to have impacted these children intergenerationally.

What needs to happen - Learning points	
1	All assessments of children should be strengthened to ensure a systematic and multi-agency approach using models that include • The child's developmental needs – including consideration of risk and resilience. • The capacity of all parents/carers in the household to respond to those needs to understand family functioning. • Family, cultural, and broader environmental factors. (Assessment Framework Working Together 2023)

[18] Brandon, M et al RR404_-_Indicators_of_neglect_missed_opportunities.pdf (publishing.service.gov.uk)
[19] Duncan and Reader (2003) referenced in Murphy, M & Rogers, M in Working with Adult orientated issues.
[20] Working_together_to_safeguard_children_2023_-_statutory_guidance.pdf (publishing.service.gov.uk)
[21] Jo Fox 2024 Strengthening Practice: Strengthening Assessment
[22] Adverse childhood experiences: What we know, what we don't know, and what should happen next | Early Intervention Foundation (eif.org.uk)
[23] A practical handbook on Adverse Childhood Experiences https://phwwhocc.co.uk

2	Strengthen understanding of children's lived experiences in the context of any additional learning and neurodiversity factors, their developmental stage and what children need from parents and services to thrive and be protected from harm.
3	Patterning tools such as chronologies to support analysis, particularly where neglect is being considered, form the building blocks of good practice. Practitioners require support and time from their managers and agencies to undertake this in their daily practice.
4	Practitioners and managers across adult and children's facing services strengthen their knowledge and understanding of the impact of parental mental health difficulties on the care of children and family functioning. This must include: • Parental strengths and support needed to sustain wellbeing. • Understanding parental capacity and functioning concerning preoccupation, availability, and ability. • Identification of protective and resilience factors for the child(ren), including adult family members. • Shared knowledge and understanding of the above.

4.2 multi-agency working. Thresholds and decision making

What systems and processes were in place to help, support and protect Aiden, his siblings, and the family?

4.2.1 This section will explore how agencies worked together to provide help, support, and protection [24] for Aiden and his family. This was mainly provided through universal, early help and targeted mental health services such as CAMHS and CPN. The timeline provides key reference points from Aiden's perspective. This section considers what helped and what got in the way, focusing on how neglect was understood and the systems and processes in place to identify and respond to these needs. This includes thresholds, step-up and step-down processes, the interface with schools, SEN and CAMHS processes, homelessness processes, and cross-boundary practice.

4.2.2 There was evidence of some strong practice from the GP and Aiden's school, who provided continuity and enduring relationships for Aiden and his mother despite the family's move to the neighbouring authority. Given the nature of their problems, this was helpful practice. Aiden's school advocated for him and shared his voice and emotions, indicating he had some trusting relationships; the learning event shared that following the move, he would cycle from Local Authority Area 2 until funding for transport was secured. However, when his mother changed her mind about a school move, this complicated matters, and the ensuing interface of processes across the two authorities added complexity to the family's existing difficulties.

4.2.3 Transferring services across the neighbouring services appropriately set a range of processes in motion. The size of the family and their intersecting needs and history complicated matters. Significantly, a number of assumptions were made about the family, which led to conflict, misunderstanding and communication issues between services. Whilst there was clear legal guidance and a real desire from professionals to help this family, the processes could not navigate an agreed outcome for the family that met their needs. Moreover, a lack of understanding of each other's processes from the beginning led to misunderstanding, frustration, and a detraction from what else was happening in the family.

[24] Working Together 2023

This led to the issue of ‘homelessness’ becoming a preoccupying issue for many professionals. This meant that Aiden's vulnerabilities and needs were not fully noticed.

4.2.4 **The families' homeless status A** strategy meeting was appropriately the outcome of a violent incident at the family home in Local Authority Area 1. This resulted in the family's sudden move to Local Authority Area 2 to ensure their immediate safety. The authorities saw this as a temporary move, but the family stated they did not want to return as they felt unsafe. The family continued receiving CIN support from Local Authority Area 1 for three months after the move. Then, a referral was made and accepted to Local Authority Area 2 for Early Help, Level 3 Stronger Families (see timeline). At this point, the family reportedly lived in a ‘safe house’ and had settled in Local Authority Area 2. Many of the services for the children were transferred; for example, the younger children transferred schools to Local Authority Area 2, and Local Authority Area 2 services managed the health visiting services. There was a reported delay in the transfer of health visiting records, and a formal handover was not undertaken; this would have been best practice and helped to understand the history of the case. The Local Authorities' early help services (Stronger Families) actively supported the family. However, a formal case transfer meeting would have been helpful and ensured the history was fully understood, including what worked well and any barriers to supporting the family. This is particularly relevant as we explore the cross-boundary responses.

4.2.5 Within a few weeks of the case closing in Local Authority Area 1, the younger children’s Local Authority Area 2 Primary School alerted MACH that the family was reported to be at risk of imminent eviction. Housing services from Local Authority Area 2 and Local Authority Area 2 liaised appropriately, and the family's housing status was clarified. It stated that the family was temporarily placed in Local Authority Area 2 due to threats of violence, and the Police and Local Authority Area 1 Housing Solutions have investigated this and assessed the property as safe to return to. It is unclear when and how this was communicated to the family, who was responsible, or what support was offered to facilitate their move back to their home address (primary residence).

4.2.6 The family were, therefore, assessed as no longer needing temporary accommodation and had a property to return to. However, the family did not believe they were safe; they had been in Local Authority Area 2 for over four months and wanted to stay. They refused to return to their primary residence in Local Authority Area 1.

The following chronology evidences the ensuing cross-boundary service responses.

Housing timeline

South Tees Safeguarding Children Partnership

- Area 2 Housing Solutions (Area 2 Housing) could not support the family as they have a primary residence in Area 1 and no local connection to Area 2. Area 1 had funded the temporary accommodation - up to 6 months
- Area 2 MACH /Stronger Families seek to refer the case back to Area 1 as the family's primary residence is there.
- Stronger Families make a **Homelessness duty to refer** [1] to Area 2 Housing advocating for the family to remain in Area 2. However, in light of recent information, this was not accepted.
- Correspondence from Area 1 Housing Solutions they would accept a homeless application from the family.
- Correspondence between Area 1 and Area 2 MACH to transfer the case back to Area 1. Declined family deemed to be living in Area 2 and housing to liaise and agree whose responsibility the case was.
- The family handed over the keys to their primary residence. Parents were not available to discuss housing solutions. Area 1 Children's Services agreed to short-term payment for current temporary accommodation.
- Meeting between Area 2 Housing and MACH. Area 1 Children's Services not in attendance.
- By now, the family have been living in Area 2 for nearly 9 months.
- Family stepped up to social care due to the risk of homelessness. CIN assessment commenced.
- Family received a letter of eviction. Request for temporary accommodation whilst family bid for properties.
- Request declined from Area 2 Housing. Area 1 Housing dealing with the homelessness **'relief duty'** [2].
- Area 1 Housing make an **'intentional homeless decision'**
  New baby born.
- Mother contacted Area 2 Housing and was advised that Area 1 Housing's 'intentionally homeless' decision was being reviewed.
- Area 2 Housing sent parents a letter advising them they could only offer advice and guidance unless circumstances change. They could not accept a homeless application.
- Meetings and advice regarding housing with Area 2 Children's Social Care. Temporary funding for accommodation will end from Area 1 children's services. The property owner is seeking legal action to recover his property.
- Family registered with Housing Associations.
- Thirteen months since the family moved. A meeting request by Area 2 Children's Services with Area 2 Housing. No one is paying for the property, and the property owner is seeking possession. The structure of the home is poor. Concerned the family will not be able to secure a property without a reference. Informed that the family declined properties due to the locality.
- Homeless assessment undertaken by Area 2 Housing. Homelessness duty accepted.
- Temporary accommodation secured for family.
- The family declined to move as it was so close to Christmas.
- Case closed to children's social care, stepped down for early help support. Rationale housing is the key issue, and Area 2 Housing has accepted responsibility; the family are now bidding for properties.
- In the new year, a further temporary housing offer was made. The mother stated she was confused because the offer was temporary, and the area and temporary move were detrimental to the family.
- End of **S188 duty** [3] from Area 2 Housing. The family had not accepted the temporary accommodation offer.
- The family was advised of this by letter; the social worker copied in.
- Within three months, Aiden died.
- No change to the family's housing situation.

1 The duty by some public authorities to refer a person to a local authority if they are homeless or threatened with homelessness. Shelter Legal England - Homelessness duty to refer - Shelter England

2 Where a local authority is satisfied that an applicant is homeless and eligible, it must take reasonable steps to help the applicant secure that accommodation becomes available for at least six months (56 days). Shelter Legal England - Local authority duty to relieve homelessness - Shelter England

3 This refers to the local authorities' duty to provide homeless applicants with interim accommodation while carrying out enquiries.

4.2 7 This housing chronology shows how questions over the family's housing status became conflictual, complicated, and preoccupied the mother and the services involved, despite all professionals' efforts to support the family and find a resolution. This meant for Aiden and his siblings, the threat of homelessness became the focus of intervention and threshold decision-making for children's services. The impact must be considered in terms of the need for the children to have a safe and secure home and the stress reported by the mother on her mental health. We also know that Aiden said that his housing circumstances were a trigger for his self-harm, and he reported his lack of any private space to be difficult for him. Professionals reported that engagement with the parents (mother) in finding a housing solution was difficult.

4.2.8 At the transfer point to services in Local Authority Area 2, a clear planning meeting or discussion should have been held involving all relevant services, including housing, the police, and the parents, to help understand the family's situation and agree on a plan. (see 4.2.4) This was a complex and large family with an extensive history of neglect and a range of needs that required effective handover planning to ensure all the children's and parent's needs were considered. This would have been a time to clarify the housing process to the family and professionals. It would also have allowed Local Authority Area 1 Housing Solutions to proactively share information about a vulnerable family temporarily placed in a neighbouring authority funded by Local Authority Area 1. The family were managed in Local Authority Area 1 at this point as Child in Need. However, at the point of transfer, the family was referred to early help. This level of need did not reflect the family's situation, Aiden's needs, vulnerabilities, or the temporary housing situation, as these matters were not fully addressed or resolved. A planned handover could have avoided some of the subsequent assumptions and challenges over responsibility that got in the way of helping this family to navigate and understand some of the cross-boundary systems and services.

4.2.9 **Thresholds for neglect** presented numerous challenges for practitioners, reflecting debates, research, and definitions regarding neglect. Local authorities manage this by providing a 'continuum of need', which provides an agreed-upon multi-agency framework to ensure children and families get the right level of support at the right time.

4.2.10 The NSPCC research *Too Little, Too Late: The Multi-agency Response to Identifying and Tackling Neglect* [25] reflects some of the current challenges about thresholds for neglect. Research shows professionals made referrals and were confident about identifying neglect. However, they then shared action was not taken when the threshold for Section 17[26] was not met, or a short-term intervention fell short of what was needed. A sense of 'waiting' until cases increase in seriousness has been prevalent in research over many years. Patterns of referral, step up and step down, episodic intervention and varying levels of engagement are seen here for Aiden and reflect how neglect was managed across local systems.

> *"professionals in England are tasked with deciding when omissions in care reach the threshold of 'persistent' 'serious harm'. This is difficult within a child protection system heavily skewed towards thresholds and recording specific 'incidents' rather than patterns. Professionals wanting to respond to neglect are essentially having to do so in a system that is not designed to support a response."*
>
> *NSPCC Too little too late*

[25] Too little, too late: identifying and tackling neglect | NSPCC Learning

[26] The Children Act 1989, Section 17 is the duty placed on the local authority to safeguard and promote the welfare of children within their area who are in need. This includes a child's mental, physical, and emotional needs.

4.2.11 The STSCP Neglect Strategy[27] and associated Framework and practice guidance[28] guide practitioners in exploring and identifying neglect and causal factors, the impact on the child's developmental needs and associated risk factors. While this is clear and sets out the partnership-wide commitment to reducing neglect, it provides clear principles for practice and forms one of the key priorities of Safeguarding Partnerships. However, it does not support practitioners in terms of ***what*** to do and **how** to identify the right service response and resource. (NSPCC 2023) Research shows a lack of knowledge about the threshold for intervention when neglect is cumulative [29]. This needs to be understood in the wider context of how the Safeguarding Partnership meets the needs of children in need of help and support[30] where there are identified needs and vulnerabilities and how this underpins systems and practice for Neglect. (REC)

We have complicated matters by becoming preoccupied with 'thresholds'. For practitioners trying to negotiate services for children, the threshold could be seen as the gulf between neglect (unmet need) and 'neglect' (officially defined)

Daniel, B Why have we made Neglect so complicated? Taking a fresh look at noticing and helping the neglected child 2015

4.2.12 A Graded Care Profile Assessment [31] commenced when Aiden was 15. This evidence-based tool helps professionals measure the quality of care a parent or carer provides to meet the child's needs. Whilst it is positive this tool was being used; it should have been considered at a much earlier point when neglect was identified so that effective measures and interventions could be put in place. It felt like too little, too late, and had little meaning because, within six weeks, the case was closed to children's social care, showing a poor understanding of the tool's fidelity and the nature of neglect and, specifically, this family's particular issues. This seemed to have occurred in a period when there were a number of social work changes through temporary staffing arrangements; these organisational difficulties would have likely impacted workloads and capacity to fully appreciate the history and needs of such a complex family history.

4.2.13 There were two strategy meetings in Local Authority Area 1 (see timeline) and one in Local Authority Area 2. The first Strategy Meeting in Local Authority Area 1 progressed to an Initial Child Protection Conference (ICPC). The multi-agency decision was that the threshold for child protection was not met. Whilst this decision-making is outside of the scoping period for the review, it is relevant because it shows the significance of multi-agency practice in relation to cumulative neglect when the family moved to the neighbouring authority. This is mirrored in the children's continuing poor lived experiences, thresholds, and decision-making in the current local authority. (REC)

4.2.14 The risk of homelessness led to the family stepping up to social care in Local Authority Area 2. (see timeline for situational risks) Mother subsequently withdrew her consent to child-in-need support, there was a multi-agency decision to close the case, and the family was stepped down for early help. This seemed to be based on the imminent risk of homelessness being reduced despite the family had still not secured a permanent home base. This decision did not include any critical thinking about ***why*** mother had withdrawn her consent or informed by analysis of the wider family's vulnerabilities, adversity, or history. Professional curiosity is a key barrier to effective information sharing and is of relevance here.[32] Within two days of mother withdrawing consent, the GP shared his concerns with the health visitor about how mother was coping. GPs have a crucial role in supporting maternal mental well-being: "*They have an overview of issues affecting individual family members of a family which in combination may impact on the welfare of a*

[27] South Tees neglect strategy - 2024-2027
[28] neglect-framework-and-practice-guidance.pdf
[29] Social Workers' Perceptions of the Nature of Child Neglect: A Systematic Literature Review | The British Journal of Social Work | Oxford Academic (oup.com)
[30] Chapter 3 Working_together_to_safeguard_children_2023_-_statutory_guidance.pdf (publishing.service.gov.uk)
[31] Add ref.
[32] Multi-agency working and information sharing: learning from case reviews | NSPCC Learning

child." [33] This was a good oversight and review of the mother's mental health by the GP; however, there is no evidence of this informing wider multi-agency practice and significant information sharing with the early help support already involved with the family. Records do not indicate any information seeking or sharing between the GP and Stronger Families. Good practice was a follow-up home visit by the health visitor; it is of note that the mother opened up to the health visitor that she was fearful of social service involvement.

4.2.15 The intervening four months showed two multi-disciplinary meetings where concerns were raised about the children's needs and reports of the mother's disengagement with her mental health support. This led to further referrals to Local Authority Area 2's MACH, where the threshold for Section 17 was not met. A subsequent referral from the health visitor detailing the mother's mental health deterioration, poor structural conditions of the home, financial difficulties and cumulative neglect was accepted within a short period, and the family stepped back up to child in need. This showed inconsistency in the assessment and decision-making over step-up processes. (REC)

4.2.16 This was a period of escalating concerns about Aiden's mental health, his anxiety, disengagement with school and the request to move school to Local Authority Area 2. There were increasing concerns about threats to harm himself and others. This was alongside his mother's deteriorating mental health and contextual issues over neglectful home conditions, financial difficulties, and homelessness threats. A strategy meeting was held, appropriately indicating the increased risk level for Aiden and its direct impact on him. The matter progressed to an Initial Child Protection Conference (ICPC). The conference did not include school representation (school holidays), the involved health visitor (due to holidays/leave), or the father due to childcare issues. There was good representation from LD CAMHS and the Consultant Psychiatrist for Aiden for part of the meeting. The multi-agency decision was that the threshold for child protection was not met, and the family continued to receive child-in-need support. The rationale for this decision-making is not clear and appears to be based on the risks decreasing over a specific incident (focused on Aiden's behaviour) and the mother's dispute that she had any mental health difficulties. The impact of longstanding neglect on Aiden and his siblings, his particular vulnerabilities, and the parental capacity to make the necessary changes over time do not appear to have been appreciated. Professionals at the learning events shared how unusual it was not to agree on the threshold at ICPC. This directly mirrors Local Authority Area 1's decision-making two years before. There was considerable frustration about this outcome; however, there does not appear to be any professional challenge to this.

4.4.17 This decision is a concern, particularly considering his escalating behaviours and emotional distress, as it fails to recognise Aiden's increased vulnerabilities where neglect could lead to serious harm. Research by Brandon et al 2014 and Sidebotham et al. 2016 in studies of child reviews identified a number of pathways through which neglect could lead to serious harm or death. They identify eight categories of neglect[34] of relevance for Aiden and forms part of neglect's complex and cumulative nature. They sought a framework to identify opportunities for prevention and protection and, thereby, improvements to practice. These themes can be seen in this review and raise questions for the partnership of understanding cumulative neglect and harm and significantly appreciating the increased vulnerability and

6. Suicides and self-harm in vulnerable adolescents with mental health problems associated with early or continuing physical and emotional neglect

[33] GPs and primary healthcare teams: learning from case reviews | NSPCC Learning

[34] TRIENNIAL_SCR_REPORT_2014_to_2017.pdf

risks for children with a range of social, educational, and mental health needs related to learning disability and Autism. (REC)

4. 2.18 **SEND processes:** Aiden had an EHC Plan to meet his needs, which his secondary school in Local Authority Area 2 was meeting. Aiden remained at this school when the family moved to Local Authority Area 2. He had good relationships and could share his feelings and emotions; good practice from the school was listening and acting on safeguarding concerns, where his voice was heard. This was a mainstream school, and as his emotional and behavioural needs increased, he required additional 1-1 support. He also received therapeutic counselling through the school, and his timetable was adjusted when his anxieties about his exams became more pronounced.

4.2.19 The timeline shows the events and risks surrounding the family's move. By age 15, Aiden's behaviour at school was becoming increasingly challenging. His attendance had dropped significantly, and he was suspended fifteen times in a ten-month period. He was also becoming increasingly anxious and struggling with negative feelings.

This corresponded with the following (see timeline)

- Aiden was seen by the GP and was referred to CAMHS.
- Mother was asking for a school transfer, relating his anxiety to the pressure of exams in school.
- A referral for mental health support for mother was declined as she was registered with Local Authority Area 2 GP practice and was closed to community mental health services here due to non-engagement. This caused a delay in her receiving support.
- A strategy meeting was held to consider the worries about Aiden's emotional well-being, the persistent neglect issues, and the situational worries. This was good practice.

4.2.20 Significant efforts were made by Aiden's school, who knew him and his family, to provide continuity of educational care and keep him at school. It can be seen that with the best intentions, there was some confusion about the cross-boundary processes and responsibilities that got in the way. Local Authority SEND processes routinely work across boundaries to find schools that meet the needs of children with additional needs; in this case, the school was mainstream, and Aiden's needs through his EHCP were detailed. His school appropriately applied for additional emotional and behavioural support as his needs increased.

4.2.21 Difficulties arose when the two local authorities worked together to secure a school move at the mother's request. The consultation process with the identified school in Local Authority Area 2 was carried out within the statutory timescale. This was reviewed at the mother's request when the preferred school stated it could not meet Aiden's needs. Direct observation and assessment were undertaken, but the school's decision remained unchanged. Alternative (educational) Provision was suggested. The timing of the request and subsequent review was around the summer holiday, so there was delay. The process was challenged by the mother and Aiden's current school, and subsequently, the mother requested that Aiden be home-educated. While professional challenge and advocacy are positive practices, this can be seen as contributing to the mounting frustration across many agencies, complicating matters further in terms of effective multi-agency working as the matter was not satisfactorily resolved, the impact for Aiden was that he disengaged further.

4.2.22 A further complication can be shown in how information was shared across boundaries where there was a child with an EHC Plan. This means there should be communication between the old and new authorities where there is a

duty to transfer the EHC Plan to the new authority on 'the day of the move' (SEND code of practice[35] and Regional Cross-boundary Procedures[36]). Whilst the move was initially seen as temporary, the point of referral into Local Authority Area 2 MACH would have been an appropriate point to formalise the transfer. This was not done, meaning there was a 10-month delay, but its omission in multi-agency planning was more significant. This did not prevent Local Authority Area 2 SEND from taking responsibility for his EHC Plan when they were formally notified. Still, it became a point of challenge and misunderstanding and further complicated by the family's disengagement with education. It was important to keep a focus on what was happening for Aiden in the context of his family's situation. The involved professionals knew all the information and knowledge about Aiden and the family. Certainly, the CIN assessment process, Strategy Meeting, and subsequent ICPC was an appropriate multi-disciplinary space to gather information and analyse needs, vulnerabilities, and risks. Significantly, there were opportunities to resolve professional differences and/or ensure appropriate resolution if an agreement could not be reached. [37]

Why does it matter?

Reflecting on these findings helps to evaluate how well agencies worked together to help, support, and protect Aiden and his family. Working Together 2023 emphasises that successful outcomes for children depend on strong partnership working. Analysis from case reviews demonstrates the importance of information sharing, seeking and collaborative working within and across agencies. For Aiden, it is clear practitioners worked hard to respond to his needs and tried to support the family's complex needs and their situation. However, this was compromised by wider systems and processes to identify and manage chronic and cumulative neglect, Aiden's additional needs, his specific vulnerabilities and behaviours, and cross-boundary and collaborative working to resolve professional disagreement.

What helps agencies work well together? When considering some of the key components of effective multi-agency working [38] Several factors got in the way. These include information sharing and communication, a clear understanding of roles and responsibilities, agreed-upon outcomes, and an understanding of local resources and services. There were a number of existing opportunities and/or events where agencies came together to share information and work collaboratively. Making good decisions about children "*requires professionals to fully understand what is happening in a child's life. Part of this is about having access to all the information known about the child."*[39] Good information sharing is about sharing and seeking information. Fundamentally, it is about having systems and processes that work ***for*** individual children. The Lord Laming 2009[40] when talking about interagency working makes it clear that *"it's not about structures it's about making it work out there for children."* Whilst agencies held significant information about the family and were passionate and proactive in supporting Aiden, much of the professional narrative was complicated by unresolved discord over some key processes. This meant that Aiden's needs and risks were not always the main focus.

Cross-boundary responsibilities The point of referral to Local Authority Area 2 was the opportunity to share the history of the case in a handover meeting, which would have been best practice given the issues (that led to the move)

[35] SEND code of practice: 0 to 25 years - GOV.UK
[36] https://www.teescpp.org.uk/procedures-for-the-safeguarding-process/15-regional-protocol-for-protecting-children-who-move-across-local-authority-borders/
[37] 17. Professional Challenge and Resolution of Professional Disagreement - Tees Safeguarding Children Partnerships' Procedures
[38] MultiAgencyReform_Kantar_Report.pdf
[39] Child Protection in England National Review Arthur and Star 2022
[40] The Lord Laming 2009 The Protection of Children A progress Report in England Chapter 4 Interagency working

and the longstanding complex family issues and needs. This should have included a multi-agency discussion about the children's needs and specific issues relating to the temporary housing situation and any resource issues, transfer of the EHC Plan, agreed threshold, and the role and responsibilities of services across the authorities. Regional cross-boundary processes and guidance were not followed. In this case, it was clear that professionals did not fully understand each other's roles and responsibilities or the statutory guidance around housing and SEND. Part of the frustration was about the outcome of professional challenges. It is important that professional differences and challenges are respected, and outcomes and decision-making understood. Therefore, the processes for resolving differences, taking forward actions, and providing support and services as necessary must be supported. Understanding **why** they were not followed is a question for strategic leaders; research tells us that it is important that processes are communicated to enable front-line professionals to work together and build trusting relationships.[41]

Homelessness and poor living conditions The continued homelessness issue and poor living conditions of the children, regardless of intention, understanding, responsibility and efforts by a range of professionals, meant that from the children's perspective, their needs were lost in the ongoing challenges and misunderstandings about legal processes and financial responsibilities. Interprofessional challenge, responsibility and parental blame became the focus of the multi-agency responses rather than understanding the **why** and the impact on the children. Professionals worked hard to engage the family and present solutions; however, when this did not work, professionals felt helpless and frustrated, leading to blame, challenge, and closure of services due to non-engagement. This meant the children's basic needs were not fully attended to.

Thresholds for Neglect The partnership has a comprehensive Neglect Strategy and a shared commitment to tackle, prevent, and reduce the impact of neglect on its children and young people. Practitioners have a clear practice framework and guidance to help them understand and identify neglect. However, neither of these documents helps practitioners with what to do once neglect has been identified. Aiden and his siblings were identified as experiencing neglect for most of their lives from a range of universal, targeted and specialist services. Neglect from the child's perspective is simple[42] i.e., "t*he experience of needs not being met,"* which can have significant consequences. Professionally and organisationally, it is more complex as definitions and thresholds are applied, and parental omissions in care, motivation, and capacity must be considered. In this case, there were a number of threshold decisions that are difficult to understand, given the level of cumulative neglect, adversity, harm, vulnerabilities, and parental capacity (mental health) clearly evident. Working Together 2023 defines neglect as "***The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development."*** It covers many behaviours and can exist alongside other risks, adversity (including poverty) and harms. This can make it more difficult to evaluate the most appropriate threshold and then for the practitioner to consider **what to do.** (NSPCC 2023 Too Little Too Late) Given the cumulative nature of neglect, it may be helpful to move away from a linear continuum of need when considering neglect to think about '***conversations'***[43] and develop service responses framed around *What does this child need? What do these parents/carers need to support their children to thrive.*

It is essential to understand neglect within the broader national context and significantly for this partnership, across Tees.

[41] https://learning.nspcc.org.uk/child-protection-system/multi-agency-working-child-protection
[42] Why Have We Made Neglect So Complicated? Taking a Fresh Look at Noticing and Helping the Neglected Child - Daniel - 2015 - Child Abuse Review - Wiley Online Library
[43] Ref Leeds

What needs to happen - Learning points	
5	A clear understanding of the Neglect Strategy and associated guidance should inform multi-agency discussions about 'thresholds' for neglect. These must include analysis of patterns of care, cumulative harm, the child's needs and vulnerabilities, situational risks, and the extent to which change has been affected.
6	Strengthened understanding of cross-boundary processes and roles and responsibilities to include • Consideration of historical information • Children on an EHC Plan • Families with complex needs and how thresholds were understood. • Professional challenge across local authorities
7	Strengthened understanding of housing needs in relation to Homelessness duties and Statutory Children's guidance in the context of children's vulnerability and needs across Children and Housing services.
8	Decision-making to close or step-down cases must include the multi-agency group involved with the child and family to ensure all vulnerabilities and risks are known and considered. Helpful frameworks such as Kelshall's *defensible decision-making* [44] can help where there is disagreement.
9	The promotion of "effective leadership and culture supporting critical thinking and professional challenge" and the opportunity to develop good levels of trust through "safe, professional challenge" across the multi-agency workforce at all levels. (ref Child Safeguarding Review Panel 2023/24)

4.3 Recognising and responding to suicidal ideation.

How did agencies build safety for Aiden?

4.3.1 This section considers how Aiden's additional needs, including his emotional and mental health needs, were identified and what support looked like for him and his family. It will explore what multi-agency risk management processes supported his safety and care and how these factors were understood. The Learning and Development group were particularly interested in understanding the support and guidance that was provided /shared about recognising and responding to possible warning signs of suicidal intention for professionals and for parents. Whilst this is a tragic personal death, it is important that death by suicide for young people is seen in the broader context of death by suicide of children across the Tees Valley.

4.3.2 Worries about Aiden's emotional and behavioural well-being commenced at primary school. Referrals were made to CAMHS, where his needs were assessed. There were also comments about self-harming behaviours (scratching, using pencils and rulers) were raised at this time. (see timeline) It is noteworthy that concerns and the associated impact on parenting capacity about maternal mental health difficulties escalated at the same time that Aiden expressed suicidal ideation. There was comment from services that his parents were not consistently bringing him to CAMHS appointments.

[44] Kemshall, H 2003 developed a helpful checklist.

CAMHS had offered parenting support following the ICPC in Local Authority Area 1, but the parents declined to take up this service, stating they did not need support and had strategies to manage his behaviour.

4.3.3 Within a short period of time, the violent attack at the family home occurred, and the family moved to Local Authority Area 2. This was a traumatic incident, and it is not clear what support the children received following this. The assessment that the house and community were safe for the family to return to does not appear to have been considered from how this made the children feel; the decision that it was safe for the family to return became the discord between the family and the housing authorities.

4.3.4 A significant deterioration in Aiden's emotional and mental well-being occurred in middle adolescence (see timeline); he had experienced a long history of neglect and adversity; his school suspensions increased, linked to emotional outbursts, and swearing, and he continued to express suicidal thoughts, thought of harm to himself and others and low self-esteem. Wider family and environmental factors were significant. There was a new baby in the household, his mother's mental health was deteriorating, and the family were at continual risk of homelessness with poor home conditions. Aiden became increasingly anxious. His mother recognised this and took him to the GP, who made an immediate referral to CAMHS and provided guidance. This commenced CAMHS involvement in the scoping period.

4.3.5 The assessment by the Consultant Psychiatrist did not establish a mental health diagnosis but considered whether his intrusive thoughts, impulsive behaviours and feelings could be affected by his autism. The assessment did identify long-term self-harm and suicidal thinking, and one of the triggers identified was the current living arrangements. It was decided his needs were best met by the Learning Disability (LD) CAMHS, and assessment, support, and safety planning were undertaken, including home visits. Information was shared with the school, which then completed its own risk assessment. The learning event had good reflection and discussion about what this looked like and how confident practitioners felt within the school about the risk assessment. They saw Aiden, and he expressed his feelings through his behaviour and voice. Whilst the information was shared with the school, CAMHS reflected that the safety plan was Aiden's plan. While appropriately developed and written with him, it did not help other professionals involved with Aiden or his family understand what they needed to do to support Aiden in his environment and keep him safe, as he did not want this recorded. CAMHS also reflected that the Safety Plan was not reviewed and updated. There is single agency learning for CAMHS being taken forward to address this as part of their own internal review. These factors combined to give a false sense of safety, on the one hand, a plan was in place, but on the other hand, there was a sense of worry about what he was saying, particularly for the school that heard Aiden expressing these self-harm and suicidal thoughts.

4.3.6 There was evidence of helpful relationships between Aiden and his Psychologist and specialist clinicians from CAMHS. He could initially present as reluctant through his language and behaviour, but when attended, he went on to engage well in his 1-1 sessions. However, the combination of not being brought for many of these therapy sessions and his assessed needs from the multi-disciplinary team (CAMHS) was that he needed a different type of intervention to meet his needs. His last session of 1-1 therapy was four months before his death, and in the two months before his death, this was discussed with Aiden and his parents. What this would look like had not been fully determined.

4.3.7 What was not fully known was that Aiden was not always brought for his psychology sessions; when he did attend and was supported to attend (funded by taxi), he engaged well. However, his support plan was not shared or include the wider family and multi-agency system. Multi-agency working and information sharing are highlighted in the analysis of case reviews where children have attempted suicide or died by suicide. Significant here is information that was known but not connected that should have supported the multi-agency analysis of risk, harm, and vulnerability for Aiden, and include:

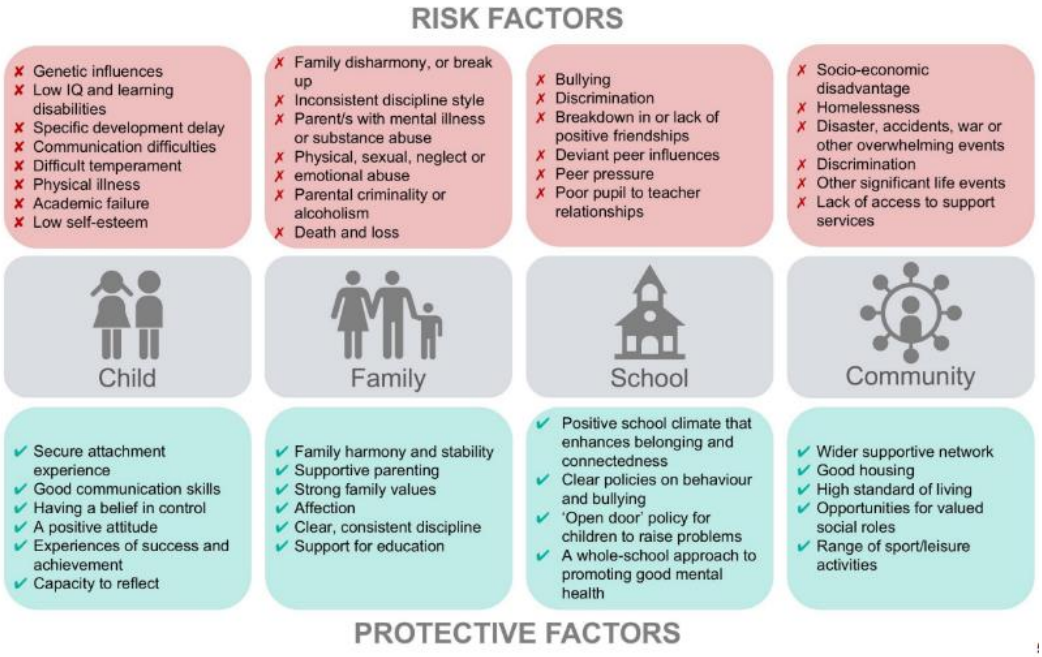
- Having a shared chronology of events which could pattern the key events connecting key social, economic, cultural, contextual and community challenges.
- The impact of Aiden's lived experiences, including chronic and cumulative neglect
- Long-standing maternal mental health difficulties affecting mothers' capacity to parent consistently or the identification of a protective adult.
- Limited understanding of what could have contributed to self-harming behaviours and suicidal thoughts.
- The identification of any protective or resilience factors
- The impact and increased risk of suicide associated with neurodiversity (ASD)

4.3.8 It is unclear what information parents were given about supporting safety for Aiden, and given the mother's mental health, father's invisibility to professionals, neglectful parenting, family functioning and enduring housing issues, how capable they were of engaging and supporting the safety plan for Aiden. Whilst they accessed support and help for Aiden, this was not always consistent, and the complexity of wider issues and needs was likely to have made this harder. Aiden and his family received home visits for the CAMHS service as well as 1-1 therapy appointments; however, there was inconsistency in applying the Was not Brought policy from CAMHS when Aiden did not attend his appointments, limited curiosity about what this could mean and what action should be taken. Significantly, this was not shared with other professionals outside of CAMHS, meaning his needs were not considered in the round or triangulated with other factors in his life. Whilst CAMHS did not share this information, there was no evidence of other professionals seeking this information and any professional curiosity being applied. This meant the case was stepped down without a full understanding of his mental health needs and engagement with services to support this. Furthermore, there was no appreciation of the parent's capacity to support Aiden; this could have been improved with a whole-family approach.

4.3.9 A more comprehensive understanding for professionals regarding knowledge and guidance about self-harm and suicide is needed as part of broader learning and guidance. The Tees Suicide Prevention Strategy (page 19) positively sets out a framework for further work with children and young people around:

- Promoting positive mental health
- Engaging with CYP
- Encouraging a whole school approach to mental health
- Social media
- Focusing on specific groups with increased vulnerability
- Effective postvention support

It outlines the risk and protective factors for children and young people; for Aiden, it can be seen how the intersecting child, family, social, and wider environmental factors increased his vulnerability and risk. This means agencies have to work harder to find and create safety and build resilience, which requires an interdisciplinary approach. There is an opportunity to develop this around the Preventing Suicide role that sits across public health and CAMHS. (REC)



Ref Tees Suicide Prevention Strategic Plan 2024 p19

4.3.9 The knowledge gaps and worries about identifying, supporting, and managing children with self-harm and suicidal thoughts were apparent at the learning event; this was felt acutely by the schools who were identifying, hearing, and seeing Aiden's anxiety and behaviours. So, it is important that the work currently being proposed/undertaken provides more than increased knowledge about risk and protective factors (see above)) but covers support and guidance from an individual child's perspective for professionals and provides a safe space for staff to process their feelings and emotions. This must be done collaboratively with those with expertise about the child's development and needs and those with expertise in children's emotional and mental health. It was suggested at the learning event that the model used with nursing colleges and CAMHS could support some of this process. It is critical that there are interdisciplinary discussions and safety planning about such vulnerable children and protective strategies for the systems around children like Aiden are clearly assessed and transparent.

4.3.10 Subsequent discussions with mother highlight the importance of having parents/carers with lived experience being involved in this work and learning for professionals to ensure the voice of the family are included.

Why does it matter?

It is highly likely that Aiden's death was the result of the culmination of many different adversities and vulnerabilities over time; there appeared to be no specific trigger that could have alerted anyone that he had a clear intent to do this. He had worked with mental services and engaged in developing his Safety plan; he and the family had some enduring relationships with key agencies. He was receiving (albeit not consistently) psychological intervention where he had space to process his feelings and emotions. Using the conceptual model of a ***pathway to harm*****,** there were a number of predisposing vulnerabilities and risks that were known around his learning and neurodiversity needs, parental issues, situational and environmental harms(including poverty, isolation, unknown cultural factors, housing difficulties), and basic care omissions (neglect) that were long-standing and cumulative that contributed to his pathway to fatal harm.

Whilst his death could not be attributed to any one factor, there is significant learning here about attending to the interrelationship of known risk factors, appreciating his specific vulnerabilities, social context, and the multi-agency responses to help, support and protection over his life span.

Appreciating the impact of Aiden's lived experiences. There must be a greater appreciation of the cumulative impact of multiple harms and adversity (ACEs) on a child's emotional well-being and an understanding of the growing evidence base of what helps.[45] There needs to be a focus on building resilience and protection for vulnerable children living in neglectful circumstances. This is best addressed collaboratively through a multi-agency response. Practitioners tried their best to support Aiden, but frustration over thresholds for intervention and a lack of collaborative practice got in the way, meaning understanding Aiden's pathway became complicated and conflictual.

Increased risk factors associated with neurodiversity It is imperative that self-harm and suicide ideation are identified as a significant risk factor for vulnerable young people who have additional learning and neurodiversity needs (ASD) particularly where there is long-standing and cumulative neglect. The features of neglect and the ability of parents to provide consistent, safe care must be seen as both a complicating and increased risk factor. This requires robust multi-agency assessment and support for systems around the child and family.

Interdisciplinary practice. Self-harm and suicide must be seen as part of a multi-disciplinary response to the risk of harm. Interventions and safety planning from targeted services must work collaboratively. Increased knowledge and understanding will support practice and help to develop helpful and supportive relationships. This will enable a wider systemic support plan around the child and family to increase communication and safety.

What needs to happen -Learning points	
10	Strengthened knowledge and skills for practitioners and managers in relation to self-harm and suicide. This must include • Predisposing vulnerability and risks associated with neurodiversity. • Correlation to neglect • Appreciating the impact of a child's lived experiences and adversity (ACEs) • Understanding these vulnerable children's pathways to harm
11	Clear processes are needed to support interdisciplinary practice in building safety for the child, the family, and the professional support system. Safety planning must be shared with the wider professional and family network (Single agency learning CAMHS).
12	Where children are not being brought for psychology sessions, or there are changes to the therapeutic plan, this must be shared with the wider professional network supporting the child and family. (Single agency learning CAMHS)

5: Summary and Recommendations

5.1 The purpose of undertaking this practice review has been to identify any learning following the tragic death of Aiden. Its role is not to investigate or apportion blame but to try and understand the circumstances that led to the incident from a multi-agency safeguarding perspective, to support learning and understanding, identify good practice and support leaders and practitioners in considering how other young people and families could be helped. This practice review has sought to honour Aiden's life by trying to understand what life was like for him and consider the

[45] Adverse childhood experiences: What we know, what we don't know, and what should happen next | Early Intervention Foundation

difficulties he faced. He was seen as a lively and energetic young person who felt proud of his boxing achievements, and he was described as having a wicked sense of humour. He had the support of his family and was loved. There were strong relationships and some enduring relationships with professionals who knew and helped him over time across the partnership. The loss of a child to suicide presents enormous emotional challenges and can impact the capacity to process the trauma by surviving relatives and also professionals involved with the family. The partnership is sensitive and respectful about how support can be provided.

5.2 This review has concluded that it is highly likely that Aiden's death was the result of many different adversities and vulnerabilities over time; there appeared to be no specific trigger that could have alerted anyone that he had a clear intent to do this. There is, however, significant learning here about attending to the interrelationship of known risk factors, his specific vulnerabilities, the social and family context, and the multi-agency responses to help, support and protection over time. This includes how cumulative neglect was considered across the partnership, how thresholds were applied and how roles and responsibilities were understood.

Recommendations for the partnership

Practice

Cumulative Neglect

1. STCP to evaluate the effectiveness of understanding and knowledge (its application) about cumulative neglect in practice. This should consider the Neglect Framework, Strategy, and Objectives for the Partnership and include the impact (difference) of the STSCP Adolescent Neglect Framework [46] on vulnerable young people. (learning points 1,2,3,4 and 5)

Step-up and Step-down (and closure) decision making.

2. STSCP should evaluate the decision-making in its step-up and step-down processes regarding neglect and the child's needs and vulnerabilities to ensure it is evidence-based and informed by the history. (learning points 5,8 and 9)

Appreciating family history

3. STSCP ensures practitioners are supported in developing critical thinking by providing space and time to access case information to help them understand the child's/family history. This is especially relevant at points of transfer and decision-making where neglect features. (learning points 1,2,3,4,6 and,7)

Understanding self-harm and suicidal thinking

4. STSCP should ensure that multi-agency practitioners and managers have strengthened knowledge and guidance about adolescent self-harm and suicide in relation to the coexistence of neurodiversity, learning disability and neglect. There is an opportunity to develop this around an existing public health and CAMHS initiative. (learning points 1,2,4,10,11and 12)

[46] Adolescent-neglect-framework-pracitioners-guide-Mar22.pdf

Learning into practice

5. The learning from this review is shared across the partnership. In considering the effectiveness of learning, STSCP should consider relevant outcomes from the CSPRP Learning Support Project (due shortly) to consider how best to land learning into practice locally and test local systems. (all learning points)

Systems

Thresholds for neglect

1. STSCP to seek assurance that multi-agency assessment, history, and analysis directly inform decision-making about the threshold for intervention where neglect is a key feature.
(learning points 1,3,4 and 5)

Clear pathways for help, support and protect adolescents with identified risk factors.

2. STSCP to ensure there are effective pathways for identifying vulnerable adolescents with identified risk factors (such as social, educational, and mental health needs related to learning disability and neurodiversity) in the context of self-harm, suicidal ideation and continuing neglect and emotional harm.
There must be shared accountability and clear responsibility across CAMHS, SEND and Children's Social Care for children in this pathway. (learning points 1, 2, 10 and 12)

Professional challenge

3. Strengthened understanding of professional roles and responsibilities across the partnership and consideration and appreciation of professional differences. The statutory partners to promote leadership that models critical thinking and safe, professional challenge across the multi-agency space. There must be a straightforward escalation process where professional differences cannot be resolved at the earliest stage. Outcomes from these should be understood and inform systems and practice across the partnership. (learning points 5,6,8 and 9)

Cross-boundary working

4. STSCP must promote and seek assurance that cross-boundary systems and practices across the partnership footprint are collaborative and meet the needs of vulnerable children and families. (learning point 5,6 7and 9)

Safety Planning

5. STSCP to seek assurance from CAMHS that information they hold about children's mental well-being and progress is shared with key professionals and that information is actively sought from services involved to inform shared risk assessment and support for the child and family. Safety planning for children with suicidal ideation must be shared with the family and the wider professional network and regularly updated. (learning points 11,12)

Family collaboration

6. **CAMHS and STSCP should listen to the views of parents /carers to strengthen service and practice improvements with regards to communicating and supporting parents /carers.**