MIDDLESBROUGH
Safeguarding Children Board

Serious Case Review

SCR Billy

REVIEW REPORT

Lead Reviewer: Jane Appleby

Agreed by MSCB: 20.6.18

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1. Summary of the learning from this review

1.1. Billy[1] was six years old when admitted to hospital with serious injuries having been involved in a road traffic collision on a dual carriageway, which is a busy major route through the town.

1.2. Billy lived with his mother, her partner and three siblings. He had contact with his father.

1.3 At the time of Billy's accident the children were subjects of Child Protection Plans due to neglect. The issues included the lack of adequate care and supervision of the children, and the impact of Mother's misuse of amphetamines.

1.4 This Serious Case Review (SCR) has closely examined the involvement of a number of agencies who came into contact with Billy and his family. Learning has been identified for individual agencies and for the Middlesbrough Safeguarding Children's Board (MSCB). The most significant learning is:

- Professionals should be aware of the details within the 'plan' for the case. It provides the basis for work with the family and should be used to monitor and evaluate progress
- Plans and multi-agency meetings need to consider and analyse any contact and direct work with children, and should capture the voice of the child and their lived experience
- Successful interventions to support families affected by parental substance misuse must depend on holistic approaches and for all professionals to understand the situation from the child's perspective
- When working with cases of neglect it is a risk that professionals will become reactive to each individual incident. It is important to take a step back and consider each child's lived experience over time and the impact on them of cumulative neglect

[1] It is important to try and protect the identity of the child and his family, so the name Billy has been chosen for the SCR and is not the child's name.

- There are benefits in providing preventive work and early access to help and support for children and their families
- The effective use of information, rather than just the recording of information, is critical to effective safeguarding arrangements

2. Process for conducting the review

2.1 MSCB agreed that the SCR would be undertaken using the Significant Incident Learning Process (SILP) methodology, which engages frontline staff and their managers in reviewing cases and focuses on why those involved acted as they did at the time.

2.2 Agency reports were completed where agencies had the opportunity to consider and analyse their practice and any systemic issues. These reports provided details of the learning from the case within the agency and allowed agencies the opportunity to reflect on actions and make recommendations for improving their own practice. Following these reports being submitted, practitioners, managers and agency safeguarding leads came together for a learning event. All agency reports were shared in advance and the perspectives and opinions of all those involved at the time were discussed at the event. The same group then met again to examine and debate the first draft of the SCR report. Later drafts were also commented on by all of those involved and they made an invaluable contribution to the learning and conclusions of the review.

2.3 It is stated in Working Together 2015[2] that SCR's should be conducted in a way that: recognises the complex circumstances in which professionals work together; seeks to understand precisely who did what; considers the underlying reasons that led to actions; seeks to understand practice from those involved at the time rather than using hindsight; is transparent about the way data is collected and analysed; and makes use of relevant research and case evidence to inform the findings. This review has achieved these objectives.

2.4 It was agreed that the scope of the review would begin from December 2015 when a Common Assessment Framework (CAF)[3] was undertaken to the date that an Interim Care Order[4] was made in April 2017, following Billy's road traffic collision. Relevant information prior to these dates was also considered as required, particularly any significant and relevant agency involvement with family members.

2.5 Family engagement is required as part of the SILP model of review. MSCB notified both Mother and Father were contacted and invited to contribute. Mother did not respond to a number of attempts to engage her. Father agreed to discuss his experience with the Lead Reviewer but then did not respond to numerous attempts to speak to him. They will be notified of the conclusions of the review prior to publication.

[2] Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children. HM Government 2015

[3] Common Assessment Framework (CAF) is an early help inter-agency assessment. It offers a basis for early intervention of children's additional needs, sharing of inter-agency information and coordination of service provision.

[4] Interim Care order- An order that can be made by the court before a final hearing in order to collect evidence to make a final decision about a child's future

3. Family Structure

3.1 The relevant family members in this review are:

Family member	To be referred to as:
Subject child	Billy
Mother to Billy	Mother
Father to Billy and Sibling 2	Father
Siblings	Sibling 1 Sibling 2 Sibling 3
Father to Sibling 3	Mother's Partner

3.2 There was no evidence in any of the reports submitted by agencies involved with the family that any issues of race, religion, language or culture affected events in this case. The family's ethnicity was White British.

4. The background prior to the scoped period

4.1 Prior to the dates of the key episodes considered below, a number of incidents were recorded in Children's Social Care (CSC) records. There was a S47 investigation[5] regarding concerns about the care of Sibling 2 while in Father's care during contact in 2011. The assessment concluded that Mother was a protective factor. A Working Agreement with Father was implemented to restrict Father's overnight contact with Billy and the siblings.

4.2 A second S47 investigation was undertaken in 2014 when Father did not seek medical attention for Sibling 2. A further Working Agreement was implemented with Father to restrict contact until the issues were addressed.

4.3 Mother, Father and Mother's Partner have historic incidences of domestic abuse recorded in some agency records.

4.4 The Police recorded incidents in August 2015 and again in September 2015 when Billy and other children were found on the busy dual carriageway unsupervised. Police returned the children home and gave Billy's Mother words of advice around safety and supervision. A referral was made to Children's Social Care on both occasions.

4.5 Mother approached school in September 2015 as she was concerned about Billy's behaviour at home. She reported him not listening to her, playing out away from the house, and getting into fights. School offered to support Mother and made an appointment for her to discuss her concerns with a Parent Support Advisor (PSA).[6] It is standard practice in schools to intervene early when any problems emerge. The PSA showed a clear awareness of Billy's vulnerability and chose to give Mother practical advice on good parenting, for example how to set clear boundaries for behaviour. In addition, the PSA provided Mother with a 'golden book' so she could record positive comments about Billy, to help reinforce good behaviour and encourage adherence to the newly established boundaries. This was not completed. Initially school had

[5] S47 Investigation places a statutory duty under the Children Act 1989 on Children's Social Care when they have reasonable cause to suspect that a child is suffering, or likely to suffer significant harm.

[6] Parent Support Advisors work with Schools, pupils and families to offer practical help and emotional support to families such as poor attendance, overcome barriers to learning and help parents to support their children's learning

no concerns in regard to Billy's behaviour, however unacceptable behaviour began to emerge and escalate in school, which was monitored.

4.6 Following the referral from the Police and the concerns expressed by School, CSC reviewed what information they held on the family, a Family Practitioner[7] from the Stronger Families Team (Early Help) was allocated to initiate an early help assessment (CAF)[8], which was undertaken in October 2015. This assessment focussed on Billy's behaviour, concerns for the safety of the children, parenting capability, and the family's finances.

5. Key Episodes

5.1 The time-frame under review has been divided into three key episodes, which are periods of intervention that are judged to be significant to understanding the work undertaken with the children and family. They are key from a practice perspective rather than the history of the child. They do not form a complete history of the case but summarise relevant activities that occurred, and include the information that is thought to be most helpful in informing the learning from the review.

5.2 The evidence has been extrapolated from the agency reports, the joint agency chronology and the Practitioners Learning Event.

5.3 The key episodes identified in this review are:

Key Episodes	
1	Common Assessment framework (CAF) and Team Around the Family (TAF)
2	Child Protection Planning
3	Response to Road Traffic Collision

Key Episode 1: Common Assessment Framework and Team Around the Family (December 2015 – September 2016)

5.4 Following the early help assessment undertaken in October 2015 a Team Around the Family (TAF)[9] meeting was held in December 2015, which the school and stronger families professionals attended. It was established that Mother was a single parent, not sleeping, feeling anxious, and that she was concerned about Billy. Neither the GP nor School Health Nurse were invited to attend the meeting. School agreed to monitor, support and nurture Billy, and help him cope with any difficulties outside of school. Mother agreed to attend a 10 week nurturing group at the Children's Centre. (She did not attend, stating she no longer required support.) The case was closed as Early Help felt that Mother was able to meet all of her children's basic needs and because Mother withdrew her consent for ongoing support. At the time in Middlesbrough when a person withdrew from Early Help there was an expectation

[7] Family Practitioner is assigned to a family to help families beat some of the long standing, emerging and difficult challenges that may be facing them in everyday life.
[8] Common Assessment Framework (CAF) is an early help inter-agency assessment. It offers a basis for early intervention of children's additional needs, sharing of inter-agency information and coordination of service provision.
[9] Team Around The Family (TAF) is a meeting between the family and professionals to find support and help for a family where the social worker is not at this stage, considering "Children In Need" status or "Child protection" Status.

that consideration be given to step up to Tier 4[10] to have discussions on whether there were any outstanding issues. It was decided at that time if there was a further incident that consideration would be given to progressing the referral to children's social care, on this occasion the case was passed back to Early Help to action.

5.5 During the early help assessment in October 2015 Mother revealed to professionals within the Early Help team that she attended the GP Practice for stress and anxiety and was prescribed Amitriptyline (for sleep and depression) and that the GP was monitoring her monthly.

5.6 When around 10 weeks pregnant with Sibling 3, in March 2016, Mother booked with the Community Midwife for antenatal care, and attended for a dating scan. She attended all follow up community midwifery appointments. The Father of Sibling 3 was a new partner of Mother and new into the family.

5.7 In May 2016 the Family Practitioner from the Stronger Families Team found Billy with two younger children 'wandering' unsupervised. At this point the family were not open to Stronger Families due to Mother withdrawing consent. Billy was returned home and the worker spoke with Mother and advised her that she would make a referral to Children's Social Care, which she did the same day. The SAFER referral did not meet the threshold for a Level 4 Children's Social Care assessment and so was passed to a member of the Early Help HUB who supported school to organise a Road Safety Officer[11] to work with Billy either on a 1:1 basis or in a group at school. It was also suggested that School forge links between Police, Road Safety, School and Mother. In September 2016, an incident was reported to a Teacher at school that Billy had been involved in attempting to remove 'Dusters (hubs)' from a car. The owner was angry and threatened to report the incident to the Police. The Teacher spoke to Billy about the incident and about 'playing nicely and not damaging other people's property' and no further action was thought to be necessary at this time.

Key Episode 2: October 2016 – Child Protection Planning

5.8 When Sibling 3 was born in October 2016 they were admitted to the neonatal unit following respiratory distress and neonatal seizures, requiring intubation. The Midwife had raised concerns with the hospital safeguarding team regarding Mother falling asleep during labour, not waking to check the baby, and needing 'quite a lot of prompting' whilst dressing and caring for Sibling 3. Mother was asked on four occasions if she had taken any non-prescription drugs during pregnancy but she consistently denied this. The Neonatologist and Neonatal Unit staff had significant concerns for Sibling 3 and a urine toxicology test was ordered. The results were positive for amphetamines[12], Gabapentin[13] and Benzodiazepines (Benzos)[14] so a referral was made to Children's Social Care. A Strategy meeting[15] was held on the neonatal unit and Children's Social Care stated that Sibling 3 was only to have supervised contact with parents. The Hospital safeguarding children's team challenged the Children's Social Care Team Manager with regards to the children at home remaining in parents care if supervised contact

[10] Tier 4 threshold for child protection in Middlesbrough is when a child has complex or significant needs that require specialist or statutory intervention.
[11] Road Safety Officers are responsible for the operation of road safety education, training and publicity and promotion the local area Road Safety Plan.
[12] Amphetamines are a Stimulant- Class B Speed, known to keep people awake, energetic and alert.
[13] Gabapentine- When misused it produces euphoria, improved sociability and relaxation (similar to marijuana)
[14] Benzos (Benzodiazeine) are usually prescribed for a variety of medical and mental health concerns as minor tranquilizers, often misused to counter effect of 'uppers' like cocaine, speed and E and 'downers' such as heroin and alcohol
[15] A Strategy Meeting is held when there are concerns that a child has suffered or is likely to suffer significant harm

was required for sibling 3. The Local Authority legal representative to the meeting gave the view that there were different thresholds for Sibling 3 and the other siblings.

5.9 Prior to Sibling 3's discharge from hospital, S47 enquiries were made after a hair strand test from Mother showed long term amphetamine use. This was followed by an Initial Child Protection Conference (ICPC)[16] and the children being made subject to Child Protection Plans under the category of neglect. Children's Social Care were willing to discharge Sibling 3 to home if Sibling 3's father moved into the family home to act as a protective factor. Prior to this Mother did not consider him to be her partner and informed the Health Visitor, when she made contact at an antenatal contact, that she was not in a relationship with him. This plan had been made following the discharge planning meeting, where the Health Visitor challenged the fact that Mother was still denying the level of substance misuse, despite the hair strand test results, and that there was no substance misuse services involved to support Mother.

5.10 Core groups were held to develop a child protection plan, and work was undertaken with Mother and her partner, Sibling 3's Father. Mother was invited to attend 1:1 parenting sessions, however due to poor attendance professionals felt the sessions were ineffective. At a RCPC in March 2016 the Independent Reviewing Officer (IRO)[17] stated that "presenting concerns have not been addressed and there is a clear lack of evidence to highlight a reduction in risk, although there are many positives; on that basis further work is to be undertaken to reduce the level of potential risk to the children". However, as Mother had clearly disengaged this was not achievable.

5.11 Following her hair strand test, Mother admitted to the social worker misuse of amphetamines 2-3 times per week, but claimed that her partner was not aware. The social worker negotiated Mother's consent for the drug misuse to be disclosed to him. He admitted using "skunk"[18] himself in the past but denied any current use. There is no evidence to suggest that he presented under the influence during visits or appointments. A referral was made to Middlesbrough Recovering Together Services (Substance Use and Alcohol Services) but Mother did not engage.

5.12 Sibling 3 was not developing as expected and continued to have complex medical needs requiring high level health input from the Neonatal Community Sister and other professionals (Speech and Language Therapist, Physiotherapist and Dietician). Sibling 3 was taken to all assessment and follow up appointments.

5.13 Mother restated to the social worker that she had issues with her mental health, partly due to a close family member dying, and that she used Amphetamines for motivation. Mother had also spoken to the Health Visitor but never provided an explanation as to why she used drugs despite many discussions around this and never made any reference to her mental health or bereavement being a trigger or that either of these issues were impacting on her functioning.

5.14 Billy's behaviour both at home and school continued to deteriorate. He had poor focus in class and started to arrive at school tired and with dark circles under his eyes. It was reported that he was staying at Father's house more frequently and staying up late, and was involved in friendships with much older boys. It was reported at school by another parent that Billy's

[16] Initial Child protection Conference (ICPC) must be convened when concerns of significant harm are substantiated and the child id judged to be suffering, or likely to suffer significant harm.
[17] The IRO is an independent social work manager who chairs child protection conferences.
[18] Strong cannabis resin.

Father and a friend smelt of alcohol outside the school gate and that Billy was caught throwing stones at a house. An investigation was undertaken by police and CSC, and Billy's behaviour was said to improve following the suspension of unsupervised contact with Father.

Key Episode 3: April 2017 – Response to Road Traffic Collision

5.15 On 22nd April 2017 Billy was involved in the road traffic collision that led to the decision to undertake this review. He was unsupervised on a major dual carriageway. Prior to the accident Billy was in the company of 3 older boys. Police and Ambulance Emergency Services attended the incident. Billy had reduced consciousness levels and significant haematomas to both sides of his head and required intubation and ventilation at the scene of the accident. He sustained a closed fracture to his left tibia and fibula (lower leg bones). Billy was transferred to the Paediatric Intensive Care Unit. He required major surgery to his leg. He had other wounds to his ear, elbow, shoulder and arm, which required treatment.

5.16 Following admission to Hospital both the Police and Ambulance Services made a referral to Children's Social Care. An urgent Strategy Meeting was held at the hospital attended by a range of agencies who all expressed concerns regarding the family.

5.17 Children's Social Care sought and received appropriate legal orders on the children.

6. Thematic Analysis

6.1 Thematic analysis is described as 'a method of identifying, analysing and reporting patterns' (Brown and Clarke 2006). It is helpful when there is important information, when there are large amounts of text (agency reports), and where the views and experiences of people are gained in focus groups (Practitioners Learning Event). From the information extrapolated, a number of key themes (issues) have emerged where relevant findings relating to the terms of reference considered at the outset of this review being commissioned have been incorporated. The following themes are judged to be most significant and enable us to identify learning for the MSCB and its partner agencies:

- Each child's lived experience
- Planning and review
- Parental drug **misuse**
- Neglect

6.2 Each child's lived experience

6.2.1 The need to listen to children and to make sure their views are taken into account in child protection cases was highlighted in an report analysing the findings from 67 SCRs (Ofsted 2010; The Voice of the Child: Learning Lessons from Serious Case Reviews). The SCRs had highlighted the importance of seeing, observing and hearing the child. In some of the reviews they found that the child was not seen by the professionals involved or was not seen frequently enough, and that professionals focused too much on the needs of the parents and overlooked the implications for the child. In other cases, even where the child was seen, they were not asked their views or about their feelings.

6.2.2 The United Nations Convention on the Rights of the Child (UNCRC, 1989) enshrines the rights of children to be involved in all decisions that affect their lives. Working Together 2015[19]

[19] Working Together to Safeguard Children – HM Government 2015

states that each child who has been referred into CSC should have an individual assessment to respond to their needs and to understand the impact of any parental behaviour on them as an individual. Every assessment must be informed by the views of the child as well as the family. Every assessment should reflect the unique characteristics of the child within their family and community context. It is essential to ensure that engaging with children takes the child's age into consideration (with observations of younger pre-verbal children essential) and that any tools used are age and ability appropriate. It then important to ensure that what we have learned from engaging with children has an impact on the plan for the child.

6.2.3 There were four children in the family, and agencies needed to ensure they focused on each child in all assessments, and that each child's individual needs were considered, recorded and addressed at each stage of the case. This didn't happen consistently, partly due to the complexity of the family with three different fathers and sets of paternal grandparents. The only consistent adult within the family was Mother. There were also specific concerns for a child that led to assessments. The initial focus of the case was on Billy following concerns expressed by Mother in regard to his behaviour, and the reports that he was playing out unsupervised and in dangerous places with older boys. While the focus was on Billy, Sibling 1 appears to have rarely been seen by professionals despite moving to live with their paternal grandparents stating it was due to the conflict caused by different males in the household. There is no evidence that this was explored fully with Sibling 1 at the time. Sibling 2 had reportedly stopped going to Father's for contact due to his drinking. Again, this was not pursued with the child. The children lived in a household which was not consistent and agencies were not always able to track where the children were or to see them either together or individually. The children all attended the same school however, and this would have provided an opportunity for professionals to see the children in their school setting and gain an understanding of what life was like for them and to explore their feelings and any anxieties they may have had. It is important that engaging with children on a plan is not a one-off event, but is done regularly to build a relationship and to consider the child's voice over time.

6.2.4 Good practice was identified when the Police and School, at an early stage of concerns being reported, attempted to support Billy and Mother through setting positive behaviour mentoring, road safety and assigning a PSA to assist. However, Mother disengaged early from this support. It would have been helpful to include other professionals such as the School Nurse who could have worked with Mother regarding her disengagement, discussed any health issues relating to Mother with the GP and undertaken a health assessment of Billy. Billy was given an opportunity to meet with the PSA and some good work was undertaken, but this did not continue due to Mother's withdrawal of consent.

6.2.5 It was reported by School that Billy told a worker that he had taken on some 'Child Care' responsibilities and on at least one occasion was left to look after Sibling 3. Consideration should have been given to the risks associated with such a young child caring for a baby with complex medical needs. There was also the potential that Billy was at risk of becoming a Young Carer. Mother was spoken to, and it was made clear to her by the social worker that this was unacceptable. She denied Billy's claim, and it was not pursued further with him or the other children.

6.2.6 There was insufficient consideration of the older children's relationship with their Father and the risk that he might pose to them. It was known that he had long term issues with alcohol and that he had neglected the children's needs in the past. It was only following police and

CSC involvement in key episode 2, when the children were on a child protection plan, that contact was again stopped. There had been ineffective use of written agreements on three occasions, with the plan of ensuring the children did not spend time with Father. These agreements were not enforceable and relied on Mother to make them work. There was also insufficient consideration of Mother's Partner's role in the family. He moved in after the birth of Sibling 3 and there was no meaningful consideration of domestic abuse in his past and his reported historic use of skunk. There were reports of poor relationships between him and the older siblings but these were not explored other than superficially, and little was known about the impact of Mother's Partner living in the home on the children. He was rarely present during statutory visits and he did not fully engage in any work, including the parenting programme he agreed to attend in key episode 2.

6.2.7 In larger families there is always the risk that professional's time and efforts are spent on the child most in need or those with problematic behaviour. Following Sibling 3's birth, the professional focus shifted to this child. This was due to Sibling 3 having complex medical needs, plus the realisation that Mother had been misusing drugs through her pregnancy. There was a significant increase in the number of health workers providing care and as the health experts their work very much focussed on a care plan to meet Sibling 3's medical needs, rather than the broader social issues that may impact on the siblings. However the challenge by health staff that if Sibling 3's contact was supervised, there needed to be an assessment of the impact of Mother's drug use on the other children living at home was a good one. An ICPC was held and it was acknowledged that all of the children were at risk of significant harm due to Mother's drug misuse and the associated neglect.

6.2.8 There were a number of examples where direct work was undertaken with the children. Earlier in the case the early help worker completed a small piece of work with all the children together using the 'bear cards' regarding how they felt. However, there did not appear to be any analysis of these feelings or consideration given to sharing findings with Mother or the school to understand how feelings linked to behaviours or to gain a full understanding of what was happening in family life. It has been reported that early help staff lacked knowledge and skill in engaging the children at the time. Since this review there has been a change in structure, increased support for frontline practitioners and a range of tools are now available to support professionals.

6.2.9 The school provided detailed descriptions of the older three children to core groups and conferences, and gave an insight into their emotional well-being. However the area where the children's views is recorded in the conference reports was not completed and no instruction was given to seek and provide their voices. A change of IRO while the children were on a CP plan had an impact on the oversight of the case.

6.2.10 The School Nurse undertook a health assessment on Billy and Siblings 1 and 2 which included their views. The social worker completed direct work with Billy and Sibling 2 when undertaking the assessment, using a range of tools such as 'three houses' and booklets and talked to them alone. There were fortnightly statutory visits due to the child protection plans, some of which involved the social worker seeing the children alone, however no direct work was undertaken to elicit their views. The social worker recognised that she did not see the children as frequently as she would have desired due to workload, and that she did not prioritise any direct work. Had all those involved at various times with the children discussed their findings and experience of the children with each other it may have helped professionals across agencies to draw together a wider picture of the impact on the children of their lived

experiences, particularly the emotional and practical impact of the seemingly inconsistent parenting they were receiving. The child's voice would then be available to inform assessments, planning and decision making.

6.2.11 Mother was said to be able to meet the children's basic care needs. She made all of Sibling 3's many health appointments and the children were described as well presented. This was a superficial assessment however. Mother seemed unable to consistently prioritise the needs of her children and concerns were evident at the time about her long term commitment and her ongoing attachment to the children. There was a concern that she was less interested in them when they were older and became more challenging. The emotional bond that forms between an infant and caregiver begins with the infant getting their primary care needs met and then becomes the engine of subsequent social, emotional and cognitive development (attachment theory in psychology originates from John Bowlby 1958). Had professionals fully explored and analysed the emerging issues there would have been a greater understanding of the 'meaning of the child' to Mother and to Mother's Partner, and an understanding of what life was like for the children living within their family.

Learning:

- All children within a family need to be considered in assessments and plans. The impact of a significant event for one child should also be considered from the point of view of siblings.
- Each individual child should be considered in all meetings. There should be a multi-agency consideration of the child's experiences which analyses and describes the impact on the children of their experiences since the last meeting. This should be included on the agenda for core groups and other multi-agency meetings.

6.3 **Planning and Review**

6.3.1 Two distinct phases of planning and review happened; early help (Tier 3) and child protection (Tier 4). Working Together to Safeguard Children (HM Government 2015) describes Early Help as 'a means of providing support as soon as a problem emerges, at any point in a child's life' and that 'Early Help can prevent further problems arising.' Effective early help relies upon local agencies working together to:

- identify children and families who would benefit from early help
- undertake an assessment of the need for early help, and
- provide targeted early help services to address the assessed needs of a child and family which focusses on activity to significantly improve outcomes, for the child.

Early Help is a key part of delivering frontline services that are integrated and focussed around the needs of children, starting with the completion of an early help assessment. The system in Middlesbrough at the time was that Stronger Families and Early Help Teams were locality based and would co-work with schools providing services to children and their families who required more than the universal provision of services, but who didn't meet the criteria for services from CSC.

6.3.2 One-to-one support was put in place for Billy in regards to safety without considering whether a 5 year old was able to fully understand how to manage safely and protect himself from harmful and risky situations. Young children rely on adult supervision and guidance, and it was critical that this work was completed jointly with Mother. Although it was good practice

that the school allocated a PSA to work with Billy, and this work was helpful, they did not pursue with Mother and/ or Billy why the 'golden book' was not completed and if there was anything additional that could be done to support them both. Due to Mother's patchy engagement and limited insight into her role in Billy's behaviour, it was challenging for professionals to work in partnership with her.

6.3.3 Mother had engaged well with the initial early help assessment and appeared keen to engage with support around managing Billy's behaviour and her emotional health. However Mother started to disengage and did not participate in the support offered and was more focused on Billy being the problem rather than wanting to consider her parenting of Billy and her other children. Professionals didn't challenge this. Mother had disclosed during the assessment that she had emerging mental health issues, however there was no evidence of professionals either exploring or analysing Mother's mental health. She reported that she was not sleeping and was struggling with stress, which she put down to Billy's behaviour. Considering the impact of her mood and stress would have led to an understanding of why Mother lacked motivation and her capacity to engage with change. There was no evidence that the GP was contacted in regard to Mother's mental health or medication and whether this would have an impact on her capacity, capability or emotional availability to care for her children, and to engage in the early help work. The lack of consideration of her mental health (prior to professional awareness of her drug misuse) acted as a barrier to gaining a deeper understanding of Mother's mental health, parenting challenges and the impact on the children.

6.3.4 Following the birth of Sibling 3, Mothers misuse of substances were recognised as an issue and SAFER Referrals[20] from a number of agencies resulted in a child protection response with an ICPC and a child protection plan being put in place. In some ways the child protection planning replicated the early help planning however, with the focus being on the child with most needs, limited consideration of the children's lived experience, and insufficient challenge of the parents. The focus was on the feeding of Sibling 3, including whether Mother could safely tube-feed the baby when she had been using amphetamines. There were no specific tasks in the child protection plan regarding Siblings 1 and 2 although they were named subjects of the plan.

6.3.5 A referral was made to the Middlesbrough Change, Grow, Live (CGL)[21] drug and alcohol services (previously Middlesbrough Recovering Together Services)[22] regarding Mother's amphetamine use. The aim was to provide an assessment of Mother's substance misuse, including triggers, to identify and respond to any health and social care needs such as physical and mental health issues in relation to her drug use, and to consider the impact on the children living within the household. A comprehensive assessment was not fully completed however, and no family risk management plan put in place. This was due to Mother's lack of engagement.

6.3.6 From the start of involvement with the family the focus of agency assessments and professional concerns tended to be reactive, depending on what was of most concern at the time. A more holistic view of the family and the children's experience of being parented

[20] SAFER Referrals- Situation, Assessment, Family, Expected Response, Recording – Middlesbrough multi agency tool
[21] A change of commissioning of the drug and alcohol services in Middlesbrough in 2016
[22] 'Middlesbrough Recovering Together (MRT)' is the umbrella term that encompasses 3 different organisations within it, namely- 1. Foundations (prescribing), 2. CGL (psychological / wrap-around support) and 3. Recovery Connections (long-term recovery, employment / societal reintegration

by Mother, Father and Mother's Partner was largely missing. Examples of this were when the focus was on Billy's behaviour or Sibling 3's complex health needs. This resulted in the other children, Sibling 1 and 2, being largely invisible. Additionally there was little evidence to suggest that the children's fathers were fully included in assessments and plans, although the child protection plan following Sibling 3's birth did include a limited assessment of Mother's Partner. He had said he was not aware of Mother's drug misuse prior to Sibling 3's birth and he refuted that it had a negative impact on her parenting, despite Sibling 3's health needs. As a household member and father of one of the children he should have been an equal part of any plan, and an understanding of his role as a increased risk or a protective factor in the family was essential. This was not undertaken until after Billy's accident and as part of the care proceedings that followed.

6.3.7 In order to fully understand a family and a child's lived experience there also needs to be consideration of the role of wider extended family, and whether they are potentially a protective factor. Involving grandparents (as would have been relevant in this case) in assessments and plans can be extremely beneficial. Little was known about the wider family, partly because Mother was not keen to provide information, but also because it was not adequately pursued by professionals. Equally there was no exploration of Mother's, Father's, or Sibling 3's Fathers own life experiences and history. Understanding parental history is vital in informing assessments of vulnerability and risk and to inform plans.

6.3.8 Engagement by Mother in the plans made for her children was partial and appeared to give the appearance of engagement rather than the reality of her limited cooperation. The Victoria Climbié enquiry[23] highlighted that professionals must maintain a 'healthy scepticism' and 'respectful uncertainty' in order to see beyond what is often being presented by parents. It requires skill and experience to keep a healthy scepticism regarding parents while still building and maintaining a trusting relationship. Mother was very plausible and showed a degree of disguised compliance. Disguised compliance involves parents giving the appearance of co-operating with child welfare agencies, without meaningfully working in partnership in the best interests of the children. Partial compliance, as in this case, can result in professionals feeling optimistic, and a belief that the parent is engaged in the plan and was able to care for the children. The optimism felt at various stages of the plans needed to be balanced against the evidence and on-going risks. Disguised compliance has featured in a number of SCRs and the NSPCC published helpful guidance in 2014: 'Disguised Compliance: Learning from Serious Case Reviews - summary of risks and learning for improved practice around families'. It considers risk factors for disguised compliance, recognising disguised compliance and learning for improved practice.

6.3.9 Over the period of this review there were a number of TAF meetings, CP conferences and Core Group meetings, and for these meetings to be effective it is important to ensure that the relevant people are invited and attend. At the learning event professionals expressed concern that key professionals who worked with the family were not always invited to meetings, and therefore did not attend or provide information that was required. For example CGL, and some health professionals including the GP. As well as having the required professionals in attendance, meetings should have clear aims and objectives and those attending must understand the purpose of each meeting, their role at the meeting, what the expected outcomes for the children are following the meeting and what their role is in the

[23] Laming, Lord (2003) The Victoria Climbié inquiry. Report of an inquiry by Lord Laming. Cm 5730, London: TSO.

plan devised at the meeting. All actions need to be SMART (specific, measurable, achievable, realistic and timely) and reviewed regularly with the family. A focused plan which involves all the relevant professionals and the family, including the children where possible, should be the aim.

6.3.10 Meetings should also invite professionals to state if they disagree with any part of the plan. Professional challenge is a fundamental professional responsibility and should be seen as a sign of good professional practice and effective multi-agency working. Any professional who has voiced their concerns and still does not agree with the plan for a child should escalate their concerns using the policy for resolving professional disagreements. It was acknowledged by the IRO at the review conference prior to Billy's accident that the CP plan had been ineffective and that the concerns had not been addressed and there had been no reduction of risk. New timescales were set, but no contingency plan was made for if there continued to be a lack of progress.

6.3.11 There was a significant range of information available to agencies who were involved with the family at the time, particularly following assessments and through the various multi-agency meetings (TAF, Strategy, ICPC and Core Groups). There was evidence of good joint working such as the school, road safety officer and the family practitioner supporting Billy, and health professionals working closely together and sharing relevant information both when Sibling 3 was born and when Billy had his accident. Children's Social Care also worked closely with hospital staff when Billy was admitted following his accident.

6.3.12 In contrast to this, the agency reports and professionals at the learning event recognised that each agency held information that others were not aware of such as the School Nurse did not initially know about Billy's behaviour concerns and was not aware of the early help support or meetings, the Police held historical information about Father and Mother's partner, and the school were not aware that there were working agreements in place regarding the children's contact with Father. The GP had been notified about CP meetings, however there was no evidence that they considered whether there was any relevant information held on their system that might contribute to the CP Plan even though all the family records were linked. Not all professionals were aware of the CAF/TAF meetings or core groups, and plans (both early help and child protection) were not updated and shared regularly. It is important that professionals see the significance of the information they hold, through good information sharing and thinking about who might hold or need to be aware of information.

Learning:

- Plans need to be:
    - Outcome focused
    - SMART
    - Involve all relevant agencies
    - Consider and involve all the children, parents and relevant wider family
    - Empower professionals to challenge if a plan is not working. (It is good practice to invite professional challenge, as a standing agenda item, at Conferences, Strategy Meetings and Core Group meetings.)

- Professionals need to identify when parental cooperation with a plan is superficial. Consideration then needs to be given to the impact of this limited engagement on the children.

- Professionals need to be curious about information held by other agencies and proactive in sharing information that may improve the understanding of a child's lived experience.

6.4 **Parental Drug Misuse**

6.4.1 It is well recognised that the misuse of drugs can have an adverse impact on parenting capacity. The links between the misuse of drugs and neglect are strong, as is denial, chaotic lifestyle, manipulation of professionals and involvement in criminal activity. Amphetamines can make people feel alert, confident and full of energy and can reduce appetite. But it can also make people become agitated and aggressive and can cause confusion, paranoia and even psychosis (Source: NHS England). There are substantial research studies and national guidance through Serious Case Reviews, the NSPCC, the Social Care Institute for Excellence, the Department of Health, and the National Institute for Care and Excellence, which show the effect parental drug misuse can have on the physical and emotional wellbeing of children.

6.4.2 It was not known or suspected until the birth of Sibling 3 that Mother was misusing drugs. It is standard practice for Midwives to ask about mental health and drug use (prescribed or illicit), which was done in the case, but Mother did not identify or confirm anything, even though she had identified to other professionals the use of a prescribed relaxant which she said was for managing stress and sleeplessness. Even when Sibling 3 was clearly very unwell in hospital Mother continued to deny substance misuse. The hair strand test showed a high-medium result indicating regular use and it was only then that Mother acknowledged that she took amphetamine. No professionals had seen any obvious signs of Mothers amphetamine use so could not prepare for any problems arising at Sibling 3's birth when the baby could have been withdrawing from exposure to narcotics. Neither could professionals offer any support nor drug treatment programmes for Mother when she was pregnant. With hindsight however, Mother's care of Billy shows that she was not managing prior to her pregnancy with Sibling 3. Even following the birth of her youngest child, Mother had consistently denied misusing drugs. Neither Mother nor her partner appeared to fully accept responsibility or recognise the need to change.

6.4.3 From the outset Mother had informed CSC and early help that she suffered from anxiety, stress and a poor pattern of sleeping. The GP was seeing Mother monthly and reviewing her prescribed medication, however, there was no evidence that the GP considered the impact on her parenting or the children themselves (Think Family)[24]. The GP didn't discuss this with any other professional, and other practitioners did not seek consent from Mother to discuss the case with her GP. Hindsight leads to the possibility that Mother may have been using her prescribed relaxant to manage her 'come down' when using amphetamines. This should be considered when a patient is being prescribed this particular medication.

6.4.4 No specialist assessment was undertaken of Mother's mental health, even when she told professionals that her use of amphetamines was largely due to her low mood and a reliance on amphetamines to motivate her. Although Mother was appropriately referred for bereavement counselling. The commissioners of Public Health services in Middlesbrough have contributed to the review and have stressed the importance of staff from all agencies promoting and valuing the importance of early and sustained engagement in lifestyle and

[24] Think Family is a whole family approach taken from Think Chid, think parent, think family: a guide to parental mental health and child welfare (social care institute for excellence 2009 (updated 2011).

behaviour services (including substance misuse and mental health services) rather than waiting until families are at crisis point.

6.4.5 Once her drug misuse was identified, Mother was referred to the drug and alcohol service. An assessment undertaken revealed amphetamine use daily. The assessment did not consider the following however:

- information related to physical or mental health
- examination of risks and triggers
- exploration of protective factors
- impact on the children (the limited assessment was entirely adult focussed)
- where drugs were stored, where the children were when drugs were purchased, and the impact on the family finances

This was due to the practice in the agency at the time and Mother's limited engagement with the service. This was not adequately challenged by the agency and information was not shared about the lack of detail and rigour in the work being undertaken. Change, Grow, Live (CGL) have improved since the time being considered by this review and they now encourage parents to engage in group work and provide a specific parenting capacity assessment, which would have been helpful in this case.

6.4.6 Professional curiosity and challenge is extremely important when assessing risk to children when there is a concern about parental drug misuse. Living in a household where a parent or carer misuses substances may not mean a child will experience abuse or neglect but it is a significant risk factor. An analysis of 175 serious case reviews from 2011-14 found that 47% of cases featured parental substance misuse (Sidebotham et al, 2016). There was no evidence to suggest that CGL used professional curiosity, sufficiently challenged Mother, or fully explored her drug use and its impact on each of the children in the household. The wider professional group also accepted Mother's version of the impact of her drug misuse and did not adequately triangulate it with what they were seeing (Mother was stated to display little or no affection or nurture once the children were no longer babies, she showed a disregard for the children's safety, had noticeable mood swings and an apparent lack of emotion about her children). There were also concerning features in the children's behaviour. When working with parents who misuse substances, professionals need to understand what is happening in the home and consider the day to day life of all family members through the child's eyes. It is only then that they can provide effective support, interventions and challenge. It is unclear what, if anything, the children knew about Mother's drug misuse.

6.4.7 There are a number of substance misuse risk assessment models available for professionals to use such as SCODA (Standing Conference on Drug Abuse), which if used in this case could have enabled a fuller risk assessment of the drug misuse, Mother's behaviours, and its impact on the children, and ultimately whether Mother was able to function as a parent in the medium to long term.

Learning:

- Professionals need to understand and consider the day to day life of all family members through the child's eyes when working with parents who misuse substances. This will enable effective support, interventions and challenge.

- The use of a formal assessment tool, such as SCODA, is of benefit. Any such assessment should be shared with all agencies involved and be updated regularly.
- A parents self-report of their drug taking must be viewed with respectful caution.

6.5 **Neglect**

6.5.1 This was a case of child neglect. Neglect is the ongoing failure to meet a child's basic needs and is the most common form of child abuse. Sometimes this is because a parent does not have the skills or support required, and sometimes it's due to problems such as mental health issues or drug and alcohol misuse. Neglect features in 60% of serious case reviews and is the most common criteria for a child protection plan.[25]

6.5.2 Identifying and assessing child neglect is difficult and monitoring progress over time, or lack of progress, can be complex, yet this is crucial for making the right decision about a child's welfare. The NSPCC have published interagency guidance that sets out the risk factors associated with neglect. 'Neglect: learning from serious case reviews'.[26] The key messages for agencies and professionals are:

- Be clear with parents about what needs to change and by when. Parents should be respectfully challenged when they fail to follow formal agreements
- When there's no long term positive change, the lead professional should co-ordinate support and services. Doing this will help agencies work effectively together
- Warm relationships between parents and children shouldn't override concerns about neglect
- Maintain focus on the best interests of the child rather than the immediate needs of a parent who may be dominant or very needy
- Improvements to poor home conditions should be regularly reviewed, especially if the family is unlikely to sustain changes

6.5.3 In many ways this was not a 'classic neglect case' as the children were reported to be clean and tidy and there was no concern about the state of the home (other than a report of messy children's bedrooms in January 2017). However the lack of supervision, the emotional detachment of Mother observed both with the children and when the children were discussed with her, the low attainment of Billy and Sibling 1 and 2 at school, poor school punctuality, and incomplete immunisations, were signs of both physical and emotional neglect. There are many forms of neglect and in this case it was predominantly supervisory and emotional neglect. Neglect was not considered in this case until the identification of Mother's substance misuse however, and the focus was then predominantly on Sibling 3. Neglect was again considered following Billy's accident when a criminal investigation was carried out by the Police. The Crown Prosecution Service declined to prosecute, but significant harm due to neglect was accepted in the care proceedings in respect of all the children.

6.5.4 There is little evidence that neglect was considered in early assessments, although a number of indicators were present over the review period such as the consistent lack of supervision of the children, the children on occasions being reported as being hungry, Mother failing to follow advice and being distracted by other priorities. Although efforts by a number of

[25] Action for Children 2013

[26] Neglect: learning from case reviews. Summary of risk factors and learning for improved practice around neglect NSPCC 2014

professionals were put in to support Mother she didn't perceive there was a problem and she did not accept that she needed additional support. Although it does appear that there were periods when the children did receive care that was appropriate and when Mother's functioning as a parent was adequate, professionals need to be aware of the multi-faceted risk to children caused by neglect and the cumulative impact. Practice in neglect cases can focus on individual episodes or issues of concern, with a failure to step back and look at patterns of parenting and the impact on children on care that dips just above and then below 'good enough' on a regular basis. To ensure that any assessment considers cumulative risk there should be a re-examination of each incident or issue so as to assess whether a multitude of factors, when considered together, constitutes significant cumulative harm.[27]

6.5.5 A chronology should be compiled for each child, which is shared between professionals to ensure that the whole picture is known and considered. Understanding the child's history over time enables the impact of care that is inconsistent to be known and critically analysed.

6.5.6 Professionals at the Learning Event were able to reflect that plans were too vague, appeared to address the symptoms but not the underlying causes, and not sufficiently focussed on what needed to change. There was limited historical information in regard to Mother's own history and whether she had experienced neglect and/or poor parenting. There was no assessment of Mother's cognitive ability or full understanding of her emotional difficulties. As professionals focussed on individual episodes there was a failure to step back and look at patterns of parenting and the impact on the children. Middlesbrough are now using the neglect assessment tool known as the Graded Care Profile 2 (GCP2). The Graded Care Profile (GCP) scale was developed in 1995 as a practical tool to give an objective measure of the care of children across all areas of need where there are concerns about neglect. The second version of the tool, known as 'GCP2' was developed to improve on GCP with the core principles of GCP remaining the same. GCP2 is a reliable and valid assessment tool in aiding practitioners in the assessment of child neglect. Middlesbrough Council are in the process of introducing Signs of Safety[28]. It is hoped that this will have a positive impact on assessments and will enable a holistic and detailed holistic view of the family. It supports professionals to focus on child safety, partnership with parents, identifying strengths that lead to safety, safety planning, and development of safety networks.

6.5.7 Professionals at the learning event highlighted the benefits of management oversight and reflective supervision when dealing with complex families, and cases of neglect. High-quality supervision and management oversight has long been viewed as a fundamental and integral element of social work practice' (DCSF, 2009:29) and it is increasingly important to other professionals. Direct work with children and families can be highly rewarding as well as complex, stressful and emotionally demanding. There was a mixed picture of how well supervision was accessed and used in this case. There were occasions when advice was taken but advice is not the same as reflective practice. The school do not provide safeguarding supervision to their early help staff, as there is no current statutory responsibility to do so. One health agency discussed the family at one safeguarding supervision session. Early Help recognised that safeguarding supervision was limited at the time, and the social worker had received three safeguarding supervision sessions which was below minimum

[27] The terms 'cumulative risk' and 'cumulative harm' were first identified by Bromfield and Higgins in Australia in 2005 who defined cumulative harm as 'the effects of patterns of circumstances and events in a child's life which diminish their sense of safety, stability and wellbeing. Cumulative harm is the existence of compounded experiences of multiple episodes of abuse or layers of neglect.'
[28] A safety and solution orientated approach to child protection case work (Andrew Turnell and Steve Edwards 1999)

expectations and there was no focus on the family history or the cumulative effect of neglect. Reflective supervision would have offered robust challenge and critical reflection, would have looked at evidence and risks, and would have provided support to professionals.

Learning:

- In neglect cases, professionals may become reactive to incidents rather than considering the child's lived experience over time. Neglect is damaging to children as its impact is cumulative.
- Good quality plans and reflective supervision is key to effectively recognising and challenging neglect.

7. Conclusions and recommendations

7.1 It is important to also learn from the good practice identified during the course of this review. Good practice across a number of agencies has been acknowledged throughout the report. A wide range of services and professionals were available to support the family and many of those professionals displayed considerable commitment to improving the care the children were receiving. This included good multi-agency working immediately following Sibling 3's birth, and a timely and appropriate multi-agency response to Billy's accident.

7.2 Partner agencies of the MSCB and those individuals working with the family have taken responsibility for this case and are prepared to learn lessons. Their involvement in this SCR has been invaluable.

7.3 The professionals involved wanted the best for this family and worked hard to support them. The 2016 Triennial Analysis of SCRs is clear that for many of the children considered in a SCR, 'the harms they suffered occurred not because of, but in spite of, all the work that professionals were doing to support and protect them.' As shown however, the support provided was often as a reaction to a crisis or event and there was insufficient focus on targeting and supporting the individual needs of the four children. Earlier consideration could have been given to whether the neglect they were suffering was a child protection concern that required a time focused plan and assessments of the parent's capacity to change. There was limited challenge of the Mother to change her lifestyle or to understand her own life experiences and how that impacted on her ability to care sufficiently for her children.

7.4 Professionals and organisations need to reflect on the quality of their services and learn from their own practice and that of others. While a serious case review allows this to happen, it should be a regular part of working in a role where safeguarding is part of the job. Effective and accessible safeguarding supervision is essential if staff are to be helped to put in practice the critical thinking required to understand cases holistically, complete analytical assessments and provide effective interventions.[29]

7.5 This SCR has considered an individual case, and has identified learning which is relevant both to this specific case, and to the wider system. At the time this review was being completed another SCR on a child to be known as Alex was also being undertaken. The Alex case found learning in regards to parental drug misuse, neglect and planning which was similar to the learning identified here. The publication of the Alex case will be delayed due to on-going parallel proceedings, however the learning should be widely disseminated, along with the learning from this case.

[29] Working Together to Safeguard Children- HM Government 201

7.6 There have been changes made within partner agencies of MSCB since the work in this case was undertaken, that will have a positive impact on safeguarding children in Middlesbrough. Details of these changes will be included in the MSCB response to this SCR.

7.6 The recommendations made below are intended to add value to the single agency recommendations and are linked to the learning established in this review.

Recommendation 1:

The MSCB to seek assurance from partner agencies that the learning from this review is being rigorously promoted, in a timely way.

Recommendation 2:

The MSCB to consider how it can ensure that plans:

- consistently capture the voice of the child and the child's lived experience with meaningful analysis
- include the engagement of all of the relevant professionals
- invite challenge from those who have concerns about the effectiveness of the plan

Recommendation 3:

The MSCB to request assurance from partner agencies providing early help about arrangements for reflective supervision for their practitioners.

Question for the Board:

How can **the MSCB** ensure that the impact on children of parental substance misuse is appropriately considered in multi-agency assessments and plans?