South Tees Safeguarding Children Partnership

Child Safeguarding Practice Review
Kingfisher

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Introduction to the review

1. This review considers systems and practice within and between partner agencies in the South Tees area specifically with regard to the assessment and safeguarding of children where there are concerns about neglect.
2. In order to identify learning and good practice, and to consider the need for improvement action, the review reflected on two cases where the neglect of young children featured.
3. The learning identified is in relation to:
    - The importance of knowing and considering a parents history and vulnerabilities
    - Recognising and working effectively with families where neglect is an issue
    - Pre-birth assessment
    - Involving fathers
    - The role of pathway (leaving care) workers
    - Impact of audits
    - Professional challenge
    - Impact of COVID 19

Process

4. Following rapid review processes[1] and consultation with the Child Safeguarding Practice Review Panel, the STSCP identified that lessons could be learnt regarding the way that agencies work together to safeguard children where neglect is a concern[2].
5. The CSPR was conducted in accordance with the requirements set out in:

[1] A rapid review is undertaken in order to ascertain whether a Local Child Safeguarding Practice Review is appropriate, or whether the case may raise issues which are complex or of national importance and if a national review may be appropriate. The decision is then made along with the national Child Safeguarding Practice Review Panel.
[2] It was agreed that this learning review would be undertaken rather than individual child safeguarding practice reviews after consultation with the National Child Safeguarding Practice Panel in December 2020.

- The Children Act 2004[3] (as amended by the Children and Social Work Act 2017[4])
- Working Together 2018[5]
- Tees Multi-Agency Children's Safeguarding Policy and Procedures

6. In order to identify learning and consider the need for improvement action, the review considered two cases. One where a young baby died, and one where a two year old was seriously injured. Both of the families were well known to statutory agencies and on either a child in need or child protection plan at the time of the incidents.
   - Lucy[6] was two years old when she was injured in an accident that was contributed to by parental neglect. Her mother was receiving support as a care leaver and Lucy was on a child in need (CIN) plan at the time of the incident.
   - Mia was less than a month old when she died. The cause of death is not yet known[7]. Mia was on a child protection plan (CPP) due to neglect concerns for her older siblings. Her father misuses drugs and is on a drug treatment programme.
7. Consideration of these cases enabled the review to focus on the systems that were in place and what works well in a strengths-based approach, alongside an exploration of where there may be learning for the system and for multi-agency practice.
8. In respect of the cases considered, personal family details will only be disclosed in this report where it is essential to the learning established during the review.
9. An independent lead reviewer[8] was commissioned to work with a panel of local safeguarding professionals from the key agencies. The lead reviewer facilitated practitioner events,[9] made contact with the families and produced this report. The lead reviewer and the panel collaborated on identifying the learning and agreeing recommendations from this CSPR.
10. All of the parents received two letters asking them to speak to the lead reviewer about their experience of professional involvement with their families. Only Lucy's father agreed to speak to the lead reviewer and his views are included in the report. Prior to publication of the learning from the review, all of the parents will be updated.
11. Agency involvement at the time was considered by each individual agency through the completion of case specific chronologies, which included analysis and the identification of any single-agency learning. From these chronologies and the rapid review information, themes were identified for discussion with the professionals involved in the cases at the practitioner events. The events also considered wider practice with children and families where neglect is a concern in South Tees.
12. An OFSTED inspection in December 2019 found that Middlesbrough Children Services was inadequate and a key focus of the improvement plan is about recognising risk and the need to improve the

[3] http://www.legislation.gov.uk/ukpga/2004/31/contents
[4] www.legislation.gov.uk/ukpga/2017/16/contents/enacted
[5] https://www.gov.uk/government/publications/working-together-to-safeguard-children--2
[6] Both children have been given alternative names to ensure confidentiality and aid the learning from the review.
[7] Toxicology tests were negative
[8] Nicki Pettitt is an experienced lead reviewer and has been undertaking serious case reviews and CSPRs since 2009. She is entirely independent of all partner agencies in South Tees.
[9] This was by virtual meeting technology due to the impact of Covid-19

management of cases of long-standing neglect. This review was therefore also seen as a way of checking on the multi-agency response to the neglect evident in the two cases being considered.

Analysis and identification of learning

13. Through the detailed consideration of both cases, the review has established the following learning:

Learning point 1:

When assessing if children require additional support or if they are at risk, it is important to always consider the parent's history and on-going vulnerabilities and the impact on the children.

14. Lucy's mother had been in care from the age of 7 due to her own experience of neglectful parenting. She had a large number of care placements, police and youth offending service involvement and periods of being missing from her placements. She was 18 years old and open to Pathways (the leaving care service) at the time of her pregnancy. Her midwife made a referral to children's social care stating that she was a vulnerable care leaver and had a history of violence when younger. The Youth Offending Service (YOS) confirmed to the review that this was related to behaviour in her residential placement and that they had had no involvement for around 4 years. Lucy's mother had a history of depression and self-harming which was not felt to be an issue by the time of Lucy's birth when she was 18 years old. Routine questions about mental health were asked and the mother stated she was well. By this time she had reconciled with her mother, Lucy's maternal grandmother (MGM) and was living back in the family home.

15. There was limited contact with the child's father either during the later part of the pregnancy or post birth. He told the review that he was not invited to any meetings and had very limited contact from professionals in respect of his daughter. He was not thought to have been known to children's social care during his childhood, but at the practitioners event undertaken for this review the GP confirmed that father's notes held information on a child protection plan for neglect in his early childhood, This was not known to those currently working the case, as it appears that GP checks had not been undertaken. This information should also have been available to CSC but changes of IT system seem to have led to it not being readily available. Father was also known to the YOS, but these checks were not undertaken. The Pathways worker knew Lucy's mother well and had met her father. She had concerns about their relationship, lifestyle and their capacity to safely care for a baby. Lucy's father told the review that they smoked cannabis regularly but denied that had ever been any domestic abuse in the relationship.

16. In contrast, Mia's family were not well known to professionals in Middlesbrough. They did not move in to the local authority area until early in 2020. It soon became apparent that there were indicators of neglect of the children in this large family[10]. A child protection plan was made in March 2020. The concerns were specifically about the impact on the children of Mia's father's[11] significant and long-term substance misuse[12] and the ability of their mother to protect them from the effects of this. Mia's father was on a treatment plan but continued to misuse drugs, including crack cocaine and heroin. The relationship between Mia's parents was relatively new and he was not the father of the older children. In

[10] In order to protect the identity of the family, the number of siblings will not be specified in this report. However Mia had a much higher than average number of older brothers and sisters.
[11] The older children have a different father.
[12] Mia's father also has older children who live in another area and there is no contact, they are not considered further by this review.

the previous local authority area, which was the same health authority area, they had received a universal health visiting service. During the review professionals involved with them reflected that mother's wider family tended to live in households with poor levels of hygiene, but that none would meet the threshold for professional involvement due to neglect.

17. It appears that the concerns in relation to the care of the children did not start until after their mother began her relationship with the father of baby Mia, following her split from the father of the older children. Mother reported struggling with depression following the break-up of this long-term relationship and this continued to be an issue at the time of their move to Middlesbrough. She was also noted to be stressed and frustrated by her new partners drug use, although it was felt that she did not fully understand or acknowledge the impact on the children, including the cost of his habit which was estimated to be at least £120 per week[13].

18. Mia's father is reported to have had a difficult childhood and to have started misusing drugs at age 12. Little was known at the time about his more general childhood experiences, but he had physical health issues as well as the ongoing substance misuse concerns and required a lot of help and support from his partner, and to an extent her older children. There were occasions known to professionals where one of the children would be sent out with mother's partner to ensure he did not use drugs. While the focus of the professional's parenting concerns was this drug use, it was expected that the children's mother would be providing the majority of parenting. This was not going to be easy with a large number of children, her depression, a lack of local family support, emerging difficulties in the relationship with Mia's father and reportedly poor quality private-rented housing, even before the Covid-19 pandemic. The need for a child protection plan was established and processes were followed.

19. Pathways to Harm, Pathways to Protection; a Triennial Review of SCRs 2011–14 was published in 2016[14] (to be referred to as the Triennial Review) and states that the SCRs considered show that there are factors in a parents' background which potentially may present a risk to a child. These include:

    - Domestic abuse
    - Parental mental health problems
    - Drug and alcohol misuse
    - Adverse childhood experiences
    - A history of criminality, particularly violent crime
    - Patterns of multiple, consecutive partners
    - Acrimonious separation

    The Triennial Review points out that these factors 'appear to interact with each other, creating cumulative levels of risk the more factors are present'. Other factors are included as significant; young motherhood; estrangement from the new mother's own parents; temporary housing or supported accommodation; lack of support from the baby's father and/or a new or unstable relationship with the father.' The average age of first-time mothers whose children were the subject of a SCR was age 19. Lucy's mother was 18 when she was born. This is compared to the national average of age 28 for first

[13] Mother told professionals that she did not give money to her partner, however they had a joint benefits claim which would have made this difficult. Was this questioned enough, particularly in light of the lack of food etc in the home?
[14] P. Sidebotham and M. Brandon et al. (2016)

time mothers. There were also housing issues, family conflict and difficulties with her previous partner. At one stage Lucy had three different homes in two weeks.

20. For Mia and her siblings a number of these issues also co-existed. For example, housing was an ongoing issue and the relationship between Mia's parents was very new when mother became pregnant. Both cases show that it is essential that anyone undertaking an assessment or working to support a family understands the importance of considering their current situation, but also that consideration is given to the potential impact of the parent's childhood experience, relationship/s and their specific vulnerabilities on their parenting and risks to their child.

21. The mental health of a parent should be considered in the context of the impact on the care provided to the child. In the cases considered there had been insufficient consideration or overly optimistic consideration of this impact by professionals working with the families. Both mother's in these cases had some mental health concerns that do not appear to have been fully explored. There was no evidence that the impact of Lucy's mother's anxiety on her parenting was considered and Mia's mother's depression was seen as a reaction to her circumstances and its impact on the children was seen to be in terms of her not being able to practically care for her large family, particularly while pregnant. The impact on the children of these mental health issues required much wider understanding and assessment.

Learning point 2:

A pre-birth social work assessment should be undertaken in cases where there are predisposing risks and vulnerabilities that warrant involvement from children's social care. This includes if there is involvement with the parent or other children in the immediate family. All professionals need to be aware of this procedure and should challenge a lack of assessment. If no assessment is to be undertaken when the parent is receiving a service from pathways, as could be appropriate, there needs to be clear reasons recorded about why this is the case.

22. In Mia's case there was a pre-birth assessment as her siblings were on child protection plans at the time. While this was undertaken the analysis could have been stronger, particularly in respect of the parenting capacity of both parents and the likely life experience of Mia following her birth. A pre-birth child protection conference was held, although it was delayed due to COVID-19. It specifically considered if the baby was likely to be at risk of significant harm from neglect, and a child protection plan was made. At the time there was little improvement noted in the home conditions, which were described as extremely poor. Concerns remained about the ability of mother and her partner to manage the behaviour of the children, despite a period of child protection planning for the older children. It was right that the baby was made subject to a child protection plan. The challenge was to ensure that the plan considered each individual child and their needs.

23. In Lucy's case no further action was taken in respect of the pre-birth referral from the midwife during mother's pregnancy, despite the unborn baby procedures stating that an assessment will take place "where the expectant parents are currently active to CSC and/or they have children who are currently active to CSC" and because of the specific vulnerabilities that the midwife outlined. Lucy's mother was receiving a service from Pathways as a care leaver and therefore technically open to CSC so a pre-birth

assessment needed to be considered, or at least there should have been a clearly recorded reason why the procedures were not being followed which was shared with other professionals. There is no evidence that the midwifery service challenged the decision.

24. The Pathways worker made a new referral around a month later, raising concerns about the expectant mother and father's drug misuse, lack of settled accommodation, domestic abuse in the relationship and the potential difficulties the expectant mother may have in caring for a baby. A single assessment was appropriately completed on this occasion and it was decided that the baby should be on a child in need plan following birth.

Learning point 3:

Clarity is required regarding the roles of all professionals involved with a family and assumptions should not be made. If a parent is receiving support from a Pathways worker, this does not mean they will be providing support to the care leavers child or specifically monitoring their wellbeing. They may have no contact with the child.

25. Lucy's mother received significant support from her Pathways worker during the pregnancy. Information shared with the review noted that there were over fifty separate contacts during these months. The main areas of need were in respect of accommodation difficulties, the fragile relationship between mother and MGM, difficulties in the relationship with the baby's father and general anxiety about the pregnancy and birth. There was a good relationship and there is no doubt that Lucy's mother benefited from this.

26. The focus of a Pathways Worker is on the care leaver and their needs in respect of health, education or employment, housing and financial/benefit issues. While a number of care leavers are also parents, the Pathways Worker is not responsible for the children, even if they are on a child in need plan as Lucy was following her birth. The decision to close this plan appears to have been made largely due to the on-going involvement of the pathways worker with her mother however. There were outstanding issues, particularly in respect of suitable housing for the young family, the relationship with MGM and contact with Lucy's father. The recording of the decision states that the case was closed as there were no safeguarding concerns identified. This was despite limited evidence of work being undertaken to support the mother with the concerns identified during the assessment. It is important that support to care leavers who are parents and their children includes a consideration of the support they require, rather than a deficit model where support is only provided if there are safeguarding concerns.

27. It was noted that the Pathways worker would continue their involvement with Lucy's mother, which was seen as a safeguard to the baby. The only professional involved specifically for the child was the health visitor and there is no evidence that consideration was given to the need for on-going parenting support to pre-empt future referrals, and to what early help services could provide to a vulnerable mother with a new baby. This was in part due to assumptions that the pathways worker was responsible for the baby, and also due to the mother previously stating that she did not wish to engage with early help support.

28. Professionals need to be curious about what the involvement of another professional actually involves. For example it is common for professionals to assume that if a care leaver is a parent, that the pathways worker's role will provide a safeguard to the baby. While this is true to an extent, there may actually be

very little involvement between the care leaver and their own worker, there may not be home visits and they may not actually ever see the baby. In this case, and generally, questions should be asked about the extent of a professional's involvement, including the level of contact, where they are seeing people, whether they undertake home visits, and what happens if their service is declined. When care leavers become parents there needs to be a recognition, clarity and full understanding of the different roles that professionals have in relation to the family / unborn.

Learning point 4:

It is important that professionals understand the need to meaningfully consider and involve fathers in assessments and plans in respect of their children.

29. In 2020 the South Tees partnership completed a CSPR called Stork that considered systems and practice with families with young babies in the area. It concluded that a child's father needs to be seen as an equal parent in order to ensure that the needs and risks to a child are met and known. It stated that professionals need to give separate consideration to how they can meaningfully engage with fathers, including those who do not live with the child. It also recognised that this can pose a challenge to professionals. In respect of both Lucy and Mia challenges were evident.

30. In Lucy's case there were concerns about the child's father but these were not assessed at the time. The mother's assertions about him were accepted and there was no evidence of any meaningful attempts to involve him in the child in need plan made prior to Lucy's birth or later when a new plan was made. It appears he continued to have contact with Lucy at the time, and although there is evidence of some on-going difficulties regarding comments on social media it was largely said to be positive by Lucy's mother. At one stage, when Lucy's mother had housing issues, Lucy went to stay with her father and his parents. There was still no attempt to undertake a proper assessment of him, to involve him in the child in need plans, or to consider what help and support his side of the family could provide to Lucy. It is now known that prior to Lucy's accident her mother had started a new relationship and was expecting a baby. Nothing was known about her new boyfriend and the impact his presence in the family may have on Lucy and on the mother's care of her daughter.

31. The father of Mia's siblings lived in another area and there was a view that he wanted no involvement with his children following his move to Middlesbrough. Some attempts were made to contact him but largely the children's mother's assertion that he would not cooperate was accepted. As well as posing a potential risk to children, fathers can also be a protective factor. For example fathers who do not live as part of the immediate family may be capable of caring for and protecting a child if this is required, as he may have been for the older siblings of Mia who were on a child protection plan due to concerns about neglect and the impact of their mother's partner drug misuse. Case reviews show that fathers are often overlooked by professionals[15], often along with the wider paternal family. This was potentially the case for both Lucy and Mia.

32. In Lucy's case her father is now her full-time carer. This review was provided with very little information about Mia's sibling's father, who appears to still be absent from their lives and the work being

[15] Hidden men: learning from case reviews. Summary of risk factors and learning for improved practice. NSPCC April 2015

undertaken with them, which is ongoing. Sandstrom et al[16] made specific recommendations about identifying fathers and male carers, including: 'being explicit with mothers about the importance of speaking to the father and including him in the process, while also ensuring that she would not be put at risk; speaking separately to the father rather than gathering information solely through the mother; and arranging separate home visits if necessary to explain the relevance of his involvement with the child, communicating a willingness to include him in decisions.' Lucy's father told the review he knew little about professional involvement with his daughter and that he was not invited to be involved in any planning.

33. As noted in the Stork review, learning has been identified nationally about the requirement for meaningful involvement with fathers by professionals working with children, and the national Child Safeguarding Practice Review Panel is due to publish a national CSPR that will consider this issue. Two recommendations were made in the Stork review. Firstly that the STSCP take the learning from the national CSPR when it is published and explore further what can be done to improve the involvement of fathers in work undertaken with families where there is a new baby. Secondly that a piece of work is undertaken to provide a better understanding from professionals in partner agencies of the role of fathers, the need to engage with fathers and to consider projects in other parts of the country that are making a difference. These recommendations will also be beneficial in light of the learning from Lucy and Mia's cases.

Learning point 5:

Professionals need to use specific neglect tools and ensure that they understand the root causes of neglect and the impact on a child over time

34. Although in many ways Lucy suffered from lower level neglect throughout her life prior to and immediately following the serious incident when she was two years old, the risk from neglect was not identified at the time. A second single assessment was completed when she was around a year old following allegations shared by a family member about the home conditions at MGM's home, where Lucy and her mother were living. Concerns were also shared about Maternal Grandmother's alleged long term and ongoing misuse of amphetamines. No further action was taken by CSC following the assessment and again it was recorded that due to the Pathway's worker and health visitor involvement there was no need for social work involvement with Lucy. This was not challenged by the pathways worker or the health visitor and there is no evidence that cumulative risk or the need for early help was considered. MGM had always been seen as a positive safeguard for the child and an assessment was required to ensure that this was actually the case in light of the new information shared. There was no consideration of using any neglect tools, such as the graded care pathway (GCP) in the case. The GCP is an assessment tool which helps practitioners measure the quality of care a child is receiving. The NSPCC state that it is effective in helping identify whether a child is at risk of neglect. In Middlesbrough there is currently improved access to training for social workers in the GCP, with course availability throughout the second half of 2021. There is also a plan to ensure wider professional training across agencies if issues with licencing are successfully addressed. Until then, the increased use of chronologies, genograms and ecograms to guide practice would be a positive step.

[16] Approaches to father engagement in home visiting programs. 2015

35. A strategy meeting was held in January 2020, when Lucy was around 18 months old. This was following an incident where MGM was allegedly physically assaulted by Lucy's mother and aunt, both of whom had been drinking and possibly misusing drugs. The assessment that followed identified that there had been significant instability for Lucy in where she lived and who cared for her, and that she presented as unkempt. This incident was treated in isolation and not considered within the context of what else was known, and there was optimism regarding mother's role in the incident. It was the view of the social work team who undertook the assessment that mother could not have been too drunk at the time as the police let her continue to care for Lucy. The review has found this was not actually the case. The police shared that while mother and child remained together following the incident, it was at a friend's home who was seen as protective. It was the officer's view that the mother was in fact too drunk to care for the child. This is an example of assumptions being made and issues downplayed without the full facts being sought and established. There is also the potential for gender having an impact, and it is interesting to consider what the outcome would have been if the perpetrator of the abuse and carer for the child had been male. Mother's self report about what happened and her denial of being drunk or under the influence of drugs was accepted without confirming with the police officers who were in attendance at the time, despite mother's history of substance misuse and aggression.

36. Mia was the subject of a child protection plan due to neglect from birth. The risk to her in light of the family's concerning situation and the experience of her older siblings meant there was a plan in place and recognition of neglect being a significant concern following the baby's birth. This was positive. While there was a degree of understanding of the root cause of the children's neglect, which was thought to be because of Mia's fathers drug use and her mother being unable to cope due her low mood and the overwhelming task of caring for her large family without family support. The use of evidenced based tools and research in this case would have allowed more understanding of the case and provided more clarity amidst the chaos. The children's social worker reported the difficulty in gaining and then considering the lived experiences of the large number of children in the family, particularly during the COVID-19 pandemic. She worked very hard to get to know each child and to communicate with all of the other professionals involved.

37. At the review event those involved felt that despite the conditions at home, the children were loved and valued by their mother, and that their earlier years had not been neglectful. This made them optimistic that the impact on the children would not be damaging, however there was no assessment of the impact on the children and limits to the understanding sought about their lived experience. The focus of the work now is in respect of their bereavement for their baby sister, but there remains a need to ensure that there is also a focus on the neglect they have suffered in the past and may suffer again in the future.

38. There is currently work going on in South Tees with developing a neglect strategy for adolescent children. This will be beneficial to the older siblings of Mia. It is planned that a strategy for younger children will be developed as the next stage. This will need to include improved awareness and use of the strategy across all partner agencies, in order to improve practice generally.

Learning point 6:

There is a need for transparent and sensitive management of auditing activity in local authorities with improvement plans. There also needs to be a system in place to consider the outcome of actions from audits to ensure they have achieved what was required.

39. The pattern of Lucy's mother missing appointments, not engaging with professionals and dismissing their concerns continued. This, and the risk associated with mother's history, was identified during an audit undertaken in May 2020 that suggested that the case needed to have a child protection rather than a child in need focus. A strategy meeting was held following the audit but maintained that Lucy continued to require a child in need plan. It was conceded however that the CinN plan must be 'really strong'. Those present at the strategy meeting agreed with the decision and no dissent was recorded. Signs of Safety was used during the meeting and the scaling of 5/6 was given, which is an average score - between 0 which means recurrence of similar or worse danger/concerns is certain and 10 which means that sufficient safety has been demonstrated. There is a reliance on scaling to determine if a child is at the right place in the system, but this review has found that scaling can be over optimistic if undertaken in a multi-agency collective setting, particularly if the parents are present. It can also be hard to understand without a clear record and strong narrative around the number agreed. Professional challenge should also be invited and expected. It is noted that when used in social work supervision the scaling was less optimistic and more reflective of what the reality was for Lucy.

40. The social work team that were working with Lucy and her mother were responsible for reviewing the case following the audit. They had a clear view that it was a child in need and not a child protection case, and did not believe there was any evidence that the threshold for child protection had been reached. They also had a view that the thresholds of the auditors were lower than was expected practice in the area, and that they did not understand the levels of concern in the community and the need for keeping thresholds at the level they were. This was despite the external audit team being asked to consider thresholds locally and a view from OFSTED that this was required.

41. Due to their OFSTED rating of 'inadequate' Middlesbrough Council's CSC had the scrutiny and support of a number of outside professionals in order to ensure improvements were made. This was clearly incredibly hard for staff, and this was evident in both the response to the audit in this case and was still evident during the review meeting. To ask the same professionals who had made decisions to review them without any further scrutiny from someone not involved is unlikely to lead to a change in the plan. Particularly when they are resentful of the challenge to their practice. Other case reviews show that it is difficult for a professional to change their mind when they have decided on a course of action, without clear changes in the situation or a significant incident that forces them to reassess their position. Decisions are made with the information available at the time, but they may need to change as more information emerges, and when risks and needs change. Professionals are required to constantly review their own views and to challenge the decisions of others as required. The audit led to a defensive rather than open minded review of the case.

42. It is not easy for those involved to review their own work in this way and to change what they had previously thought. It is also difficult for staff when outside auditors come in and those spoken to felt that they were being criticised by people who had no connection to the area. The audit was put in place as

an immediate response to the Ofsted inspection, as a 12 week plan before the strategic plan was ready to be rolled out. The initial audit happened while services were adjusting to restrictions and working from home due to COVID 19 and communication platforms were challenging. There is now a fair more transparent and integrated model of audit which includes reflective discussions with the professionals involved. There is also clearer tracking of what happens next after there has been a challenge, re-auditing of plans that were audited as inadequate, and moderation if there is disagreement about an audit rating.

43. There is no evidence that any feedback was given, or requested, by either the audit team or senior managers following the strategy meeting that was held in Lucy's case. There was also no challenge from any other agency involved in the case. So this opportunity to reconsider where the case was held within the system did not have an impact, other than the acknowledgement that the CIN plan needing to be 'strong'. There is no explanation regarding what this would involve and there was limited direct involvement with Lucy and her mother in the months that followed, although there is evidence of professionals trying to contact them. Those involved explained that Lucy's mother could be a challenge to pin down and that it was often hard to speak to or see her. There is always the risk, when a parent is a young care leaver themselves, that professional expectations of them adjust and that this leads to excuses or concessions for missed appointments, negative attitudes towards professionals and difficulties in accepting support. Care leavers have a legacy of being in care which impacts on their relationships with professionals and it can be difficult for those involved to build the relationships and trust required to provide meaningful support and challenge, yet remain focused on the care leaver's child. Honesty is required when working with care leavers who become parents, about the likelihood that their own history will impact on their parenting, and that they are likely to require on-going involvement with support services. Sadly, care leaver's children are over-represented in child protection cases and in care proceedings. Professionals must be aware of the need for an understanding of trauma informed care, the impact of adverse childhood experiences, and the need to work differently to ensure that there is the right balance of support for the parent and protection of the child.

44. Following the strategy meeting, child in need meetings were held and those involved continued to be positive about the mother's care of Lucy. There is little evidence however of much direct contact with either Lucy or her mother at this time to justify the positive picture. This was due to missed appointments but also the challenges of the pandemic. The allocated health visitor and the pathways worker, both of whom who had been seen as important parts of the child in need plan, had no direct contact whatsoever at this time. Staff at the supported accommodation were not undertaking any direct work. There was a plan to involve a family resource worker to provide hands on support with routines and boundaries, but they had no capacity and did not get involved until after Lucy's accident. Without the involvement of these key professionals, the optimistic view of how Lucy was being cared for during the period of child in need planning is hard to understand. The social worker allocated to Lucy only saw her and her mother once in the two months that followed the audit and strategy meeting, and this was outside the home for a short period of time. She has acknowledged that she was unable to do any planned work due to issues with confidentiality and lack of contact time.

45. Within two months of the strategy meeting an ambulance was called because Lucy had had fallen 20ft from a bedroom window at her aunt's house. While a criminal investigation was not pursued, there is a view that a degree of neglect was apparent. It was following the child's discharge from hospital to her mother's care, which was agreed at a complex strategy meeting by chaired by a senior CSC manager, that serious concerns about Mother's care of Lucy, who required additional care due to her injuries, once more became apparent. Care proceedings were swiftly commenced and the Local Authority where granted an Interim Care Order and a Recovery Order.

Learning point 7:

There is a need for professionals to robustly challenge themselves, each other and parents/carers when it comes to managing cases of neglect.

46. The study 'Working with Neglected Children and their Families: Linking Interventions with Long-term Outcomes' (Farmer and Lutman 2012) considers the processes that are likely to adversely affect the longer-term management of families where there are neglect issues. They are:
    - Becoming de-sensitised to children's difficulties through habituation
    - Normalising and minimising abuse and neglect
    - Downgrading the importance of referrals about abuse or neglect from neighbours or relatives
    - Over-identification with parents
    - Developing a fixed view of cases which discounts contrary information
    - Viewing each incident of neglect or abuse in isolation and not recognising their cumulative impact

47. In both of the cases considered there were indicators of the above in work being undertaken. An example was the school attended by Mia's eldest siblings, where none of the schools perceived the children to be at risk of neglect. The school reflected that the family were disorganised and at times chaotic, but that they saw no evidence of harm or significant neglect. They told the review that the children's mother needed help and support, but that this was not out of the ordinary in the community where they live. The oversight of the life experience of Mia's siblings provided to this review shows that neglect certainly featured and has had a negative impact on their well-being.

48. Curiosity and a willingness to challenge are fundamental professional traits required when working together with other professionals and with families to keep children safe. The need for 'respectful uncertainty' is widely known, but not always easy to achieve. Getting the balance right between support and challenge when working with parents can be difficult, it is a complex balance which requires skilled practitioners, reflective practice, effective supervision and professional challenge within and between agencies. The pandemic led to changes to practice that did not help professionals to engage with families or with each other. For example child in need meetings were attempted on Lucy's case in April, May and June 2020, but they had to be undertaken by telephone. This created a lot of issues, with the health visitor reporting not being able to join, and with various connection and call quality issues. Middlesbrough Council bought a number of WEBEX licences to use for these meetings, but they were prioritised for child protection meetings and social workers coordinating child in need meetings did not have easy access to them. The picture was improving at the time of the completion of the review.

49. When considering the impact on a child of a number of smaller issues, it is important to compile and consider a chronology. This can help avoid the risk of considering issues in isolation and not understanding the cumulative impact. A chronology, particularly one that includes multi-agency information, shows the full picture and a child's care over time can be considered. It enables persistent and cumulative harm to be identified. No chronology was evident for Lucy until after her accident and when the local authority decided that they needed to undertake care proceedings. This means that there was no real understanding of how poor her mother's engagement with professionals had been over time and the number of appointments that had been missed, for example. During the review there remained optimism about how engaged Lucy's mother had been, despite evidence available to the review that this was not actually the case. Those involved at the time were not aware of the child's lived experience over the months of the first lockdown as they had minimal contact with her and her mother. The contacts that did happen were for a maximum of 15 minutes and were undertaken outside of the family home. Much of Lucy's mother's support was supposed to have been provided by staff at the supported accommodation where she had a tenancy. However due to COVID there was no hands-on support or direct contact. It is now known that Lucy and her mother were spending very little time at the accommodation, instead staying with her sister. The police have a number of examples of her being warned for breaking COVID restrictions.

50. There was also optimism about the willingness of Mia's mother to work with professionals, despite evidence that she was not always engaged. She swore at the health visitor in a meeting, and was often hostile to professionals. There was only limited engagement with the resource worker who was involved to offer parenting support. Mia's older siblings were made the subject of child protection plans during mother's pregnancy with Mia. A pre-birth assessment was completed and a pre-birth conference arranged. By the time of Mia's birth her mother had asked her father to move out due to drug testing showing on-going significant substance misuse, which was positive and enabled professionals to feel she was listening to advice and willing to make changes for the benefit of her children. Those involved were optimistic that Mother would separate from him permanently. Good work was undertaken with the mother by CGL[17] to educate her about substance misuse, to enable her to identifying patterns and recognise her partner's deceit, in the hope she would be less naive about this. His presence at the family home following the birth was challenged directly with him and with the mother by those involved and information was shared between the professionals involved. This was good practice.

51. Mia's mother was seen by health professionals as an experienced parent. She breast fed her babies, which was seen as positive and child centred. There was no history of concerns from the previous area where they had lived. When it emerged that appointments for the older children were being missed, including for the six-week check and immunisations for her baby (Mia's older sibling) this was not immediately identified as of concern. There had also been a change of health visitor within Middlesbrough when the family moved to another part of town not long after arriving in the area. It was not until a strategy meeting was held in February 2020 that health professionals were aware of the neglect concerns about the children. CSC had received four referrals in around three weeks. Firstly from the police regarding one of the older siblings being out in the community unsupervised late at night.

[17] CGL provide treatment and support to those who misuse substances in the area.

Secondly from CGL in regard to mother being pregnant and the father having on-going substance misuse issues. Thirdly from the school of some of the older children stating that they were unkempt, tired and often absent. Lastly from the ambulance service sharing their concerns about the eldest sibling who came to their notice due to issues of anxiety and anger control, their concerns about the home conditions and the child having responsibility for his younger siblings. It was agreed that the children were at risk of significant harm and an ICPC was held, with the older siblings all being made subject to child protection plans for neglect - physical, medical, nutritional, emotional, educational, and lack of supervision and guidance at home. The plan included monitoring of the home and children's life experience, but was closely followed by the first COVID 19 pandemic lockdown, which had a negative impact on the plan and potentially the children, as their mother exercised her right to keep them at home and the professionals involved had to abide by their agencies rules in respect of home visits due to the pandemic. The social worker described having to view the home and see the children through a downstairs window.

52. There were some concerns about the quality of the child protection plan for Mia and her siblings. The IRO monitoring tool rated the case at a Red, highlighting the urgency of gaining the children's views and an understanding of their lived experience, as this had not been apparent. The review was told that more recently (as practice has changed and improved within Covic-19 regulations) there has been a lot of work undertaken with the children and that the social worker has developed a good relationship with them.

53. A review child protection conference was held very soon after Mia's initial conference and there was concern voiced that despite nine months on a plan there had been no real improvements for the children, particularly in regard to their supervision, school attendance, physical appearance and home conditions. Their mother had received some parenting work with a resource worker, but was reported not to engage with what was asked of her and often said that she was confused about what she had been asked to do, or that she did not have time to do it. The chair stated that a legal gateway meeting should be considered if there was no improvement by the next core group. There was no clarity regarding what these improvements were and how positive change would be measured however, and with the absence of an outcome focused plan[18] and no evidence that any neglect tools were used, this was going to be difficult. It was shortly after this meeting that Mia died.

54. There were no visits inside Lucy's home following the outbreak of pandemic and the initial lockdown in the UK until after her accident in July 2020. This appears to be due to it being a temporary supported housing unit with other residents. The 0-19 service delivery (including health visiting) were instructed to have no face to face client contacts until they received appropriate PPE, which took around three weeks. A directive was then made that the only face to face visit should be to new birth contacts, those on a child protection plan or if there was an absolute clinical need, where visits had to be authorised by service manager. This means that Lucy and her mother did not meet the criteria for a face to face visit from the health visitor until the strategy meeting was held on 19th May and it was agreed that the health

[18] In a SMART and outcome focused plan the needs of the children should be specific and linked to their growth and developmental milestones and aimed at their preferred future. Actions need to be specific, clear and linked to meeting needs and time specific, linked to a responsible person. Timescales need to be determined to help focus the interventions and progress points. Outcomes need to be stated to outline what life would be like if the interventions were successful and the child's needs were met consistently over a sustained period of time.

visitor should visit. However two weeks later the health visitor became unwell and took extended sick leave.

55. Professionals working with Lucy and her mother found that the mother's engagement deteriorated further during the pandemic. It was easier to avoid professionals or to superficially engage on the telephone or when meeting briefly outside the home. There were attempts from professionals to see Lucy and her mother, but these were not always successful. Despite this, the child in need meetings held on the telephone stated that there had been progress in the child in need planning for Lucy and a generally positive view. There is no evidence that this was actually the case however. Lucy's mother came across as managing well and this was not adequately questioned by those involved.

56. Following Lucy's accident there was a complex strategy meeting held which was chaired by a senior manager. It can now be seen that not all of the relevant background information was shared at the meeting, and the same positive feeling about her mother's care of Lucy was accepted at the meeting. The police and the allocated social worker were unable to attend, which exacerbated this. An agreement was made that Lucy could return to her mother's care when she was discharged from hospital. No other agency challenged this decision and Lucy returned home. There was good monitoring and information sharing in the days that followed, including home visits from the social worker and health visitor. It quickly emerged that her mother was not meeting her needs at this time and that Lucy was at risk of neglect. Care proceedings were started without delay.

57. In the first weeks of the pandemic the core group meeting following Mia's siblings being made subject to a CP plan was cancelled, and there is no evidence it was rearranged. There appears to have been a number of attempts by the social worker, health visitor and school nurse to see the children, despite the limitations at the time[19]. The school nurse did all she could to engage in a meaningful way with one of the older siblings when there were particular concerns about how he was managing. There is also evidence of communication between the professionals regarding who was able to have contact. Families had the right to refuse to send their children to school. There was no government guidance about vulnerable children being **required** to attend, and limited understanding of who needed to shield. In the case of Mia's siblings, there was the option of all of the school age children to attend school due to their vulnerabilities. One of the older children refused to do so, saying that it would make her stand out as a child with a social worker. Their mother chose not to send the younger children, and said the whole family were 'shielding'. The professionals involved thought this was really due to her not having to be organised to get the children to school, bearing in mind her pregnancy and the size of her family. For a family where school attendance had been a long-term issue, the pandemic gave a valid reason for the children to miss school. Most schools took some time to set up virtual learning, and it is not known what home schooling Mia's siblings had in these months. Those involved at the time reflected that it was unrealistic to think that a family with so many children, in small and inadequate housing that was often described as 'unsafe', with additional social problems could actively learn and develop via home schooling. It is known that the school undertook home visits to them and provided lunch, which was good practice.

[19] PPE was not available to community health staff until 07/04/20

58. The information shared with the review stated that, due to the family shielding, the social worker initially was only able to see the children through the window. This means that the issues that had been identified at the ICPC, which included the poor home conditions, the children dirty and dishevelled and the children's health needs not consistently being met, could continue without any meaningful oversight from professionals. Shortly afterwards home visits did start again, but just 15 minutes in the home was recommended following a risk assessment. Other concerns also emerged at the time, including the children being out and unsupervised and one of them being hit by a car when out alone on their bike. The impact on the children of their home life was likely to be additionally concerning due to Covid 19. The schools had made sure that the children had appropriate uniform and food when they attended school prior to March 2020, and although there was contact and school dinners provided, this would not have compensated for a day in school when the children were 'shielding'. Despite the enforced limitations, the social worker and health visitor maintained contact with the family and drew up a safety plan to ensure this was as effective as was possible within the limitations. This reflected a lot of positive work in the town generally from all professionals to ensure that children were seen despite the pandemic. The recording of the work undertaken at the time would have been improved by a clear record of the impact on each child and evidence of an understanding of their lived experience during the lockdown.

59. During the reflective discussion as part of the CSPR process, Mia's health visitor reflected on the challenges. She stated that there were increasingly high workload demands with CP and CIN families, recruitment issues across the health visiting service and a recent surge in safeguarding cases in Middlesbrough. This was in addition to the demands of COVID. She did not seek safeguarding supervision on this case due to the general pressures and lack of time both to complete supervision forms for all the children and to attend the actual supervision meeting. This requires further exploration by the HDFT to see if it a wider issue and they have agreed to do this. Since the incident HDFT has rolled out 1:1 supervision to all 0-19 practitioners in Middlesbrough over a 3 month period, which is more actively being sought. Group supervision has also been reintroduced.

60. There was also a more general impact from Covid-19 due to professionals catching the virus, self-isolating, or shielding which led to some reduced capacity. This accompanied increased demand due to a local 'safeguarding surge'. In their second annual report published in May 2021, the national panel described the previous year as 'an indescribably hard time for children and families' and 'a period of unprecedented test and challenge for all those entrusted with safeguarding and protecting children from harm'. There is no doubt that while the incidents that have led to this review were not due to Covid-19, it had an impact on some of the practice undertaken at the time and led to stretched safeguarding systems.

Conclusion and recommendations

61. The latest OFSTED report that considered Middlesbrough Children's Services in 2020 found that assessments were 'too often poor, leading to over-optimistic decision-making' and that many 'fail to understand children's experiences, lack clear analysis of cumulative harm, and rely on parental self-reporting to consider parents' capacity to make and sustain change." Inspectors found child protection plans often took 'too positive a view of parents' ability to sustain change', and that this leaves some

children in seriously neglectful and harmful situations.' This review has found that this was the case for Lucy and to a lesser extent Mia and her siblings, despite there also being examples of good individual practice and multi-agency information sharing and communication. A lot of hard work has gone into improvements and a more positive response from OFSTED about progress made, including in regard to the thresholds issue also identified in the review. The learning from this review should be considered as part of this improvement journey.

62. To assist in ensuring that improvements are made that make a difference to the children of Middlesbrough and the wider South Tees area, this review has also made recommendations for the STSCP.

Recommendation 1:

The STSCP to consider how it can ensure that all professionals in partner agencies are aware of and use the neglect strategy. This should involve a review of the strategy, consideration of how to relaunch it and how to monitor its use.

Recommendation 2:

The STSCP to request assurance from the Local Authority regarding improvements in the use of the Graded Care Profile and evidence based practice[20] in neglect cases, to include consideration of its use by professionals across other relevant partner agencies.

Recommendation 3:

All plans, be they early help, child in need or child protection, need to provide a clear and detailed description of who is undertaking what work with the family, which takes their role and its limitations into consideration. All members of any team around a child / core group must ensure they provide appropriate challenge if this is not the case.

Recommendation 4:

The Corporate Parenting Board to be asked to consider how they can develop the concept of being a positive 'corporate grandparent' to the children of care leavers.

Recommendation 5:

The STSCP to consider how it can ensure that the recommendations made in the STORK review, regarding the need to actively involve fathers when providing services to children, are having a positive impact to the children of South Tees.

[20] There also needs to be more use of chronologies, genograms and ecograms as part of these improvements.