RBSCP

ROCHDALE BOROUGH
SAFEGUARDING CHILDREN PARTNERSHIP

Rochdale Borough Safeguarding Children Partnership Learning Lessons Review

Child J1

Authored by: Nicki Walker-Hall

Contents

1. Introduction

1.1 This report covers the findings of a Learning Lessons Review relating to a child to be referred to as J1.

1.2 J1 collapsed in school having ingested a bag of white powder, one of nine that he had brought into school in a kinder egg. J1 was transported to hospital where he was found to have cocaine in his system although testing of the remaining white powder did not prove positive for a class A drug. J1 and sibling were removed from mothers care. A police investigation commenced in relation to neglect and possession of controlled drugs. The investigation has now been finalised with a decision of No Further Action due to insufficient evidence.

1.3 There was a significant history in relation to neglect, domestic abuse, and substance misuse which dated back to before J1 was born, and ongoing concerns which meant J1 and sibling were subject to Child Protection (CP) plans at the time of the incident.

2. The process

2.1. The circumstances of this case were discussed by the Rapid Review panel on the 19th December 2022. Most of the agencies agreed that the criteria for a Local Child Safeguarding Practice Review were met as child abuse and neglect had occurred and J1 had been seriously harmed.

2.2 The rapid review highlighted that whilst many of the learning themes had been considered in previous LCSPRs, including escalation and information sharing, that given the circumstances of this case, further analysis to identify and share learning was necessary. This was particularly relating to responding well to the voice of the child and the impact that adverse childhood experiences (ACEs) in childhood and trauma as an adult have on parent's capacity to make effective decisions and choices regarding the safety of the children.

2.2 In February 2023 a lead reviewer[1] was commissioned to work alongside local professionals to undertake the review. A project plan was developed which identified the Key Lines of Enquiry (KLOES).

2.3 In April 2023 the process was halted when testing of the remaining powder in the kinder egg did not identify a class A drug. Agencies were questioning whether the LCSPR should continue.

2.4 In May 2023 a decision was made to undertake a Learning Lessons Review as it was still felt there was learning for the agencies involved. The National Panel endorsed this decision.

2.5 Agencies were requested to complete Learning Summary Proformas of their involvement with J1 and the family during the review period, 1st July 2021 until the date of the significant incident in October 2022.

2.6 A multi-agency review panel[2] met on the 05.07.2023 to consider a number of the Learning Summary reports. The panel reconvened on the 9th August 2023 to review the remaining reports and prepare for the planned practitioners event.

2.7 The practitioners event took place on the 6th September 2023 with representative from all the involved agencies except the police, and CAFCASS.

[1] Nicki Walker-Hall has a background in health working predominantly with children. Nicki has an MA in Child Welfare and Protection and an MSc in Forensic Psychology. Nicki is an experienced reviewer of both child and adult safeguarding reviews. Nicki is entirely independent of the BSCP.

[2] The panel consisted of representatives from all the key agencies

2.8 The reviewer produced a draft report on the 16th October which was reviewed by the panel and amended in line with the panels comments.

2.9 The report was presented to the partnership in November 2023

2.10 It has not been possible for the reviewer to speak to J1 or the family. This is recognised as a limitation to the review.

3. Summary of Learning Themes

3.1 The following are the main learning themes:

- The importance of understanding and using history to inform practice
- There was an over reliance on self-report by mother
- There were a number of issues in relation to social work practice:
    - There was a lack of professional curiosity
    - Child and Family assessments lacked breadth and depth. Fathers and the wider family were not included, information was not triangulated , practice standards were not adhered to, leading to flawed assessments of risk
    - Managerial oversight was not sufficiently robust to identify and challenge frontline practice
    - CIN/CP plans were not robust
    - The voice of mother overshadowed the voice of J1
    - Opportunities to gain a greater understanding of J1 and siblings lived experience were missed
- Processes and tools designed to assist practitioners to keep children safe were not used effectively
- Agencies were not working in true partnership, leading to disagreements that allowed mother to deflect and deceive some practitioners

4. J1's story

4.1 J1 was described by practitioners as loveable, cheeky, mischievous, likes to help and likes praise. J1 wants hugs and affection and has a good sense of humour; he loves money. J1 could be physically aggressive, nosey, and hypervigilant. J1 has a good imagination and appears confident.

4.2 J1 is of White British heritage. Mother was a looked after/adopted child. Mother has a history of drug use and domestic violence. Father has also a history of drug abuse. J1 is the fourth child born to mother, J1 has contact with their siblings who reside with adoptive grandparents. J1 was a looked after child from birth, due to substances found in mother's system. J1 was returned to full time care of his mother in June 2018 when they lived in Bolton.

4.3 J1 has been open to Rochdale Children's Social Care since he moved to Rochdale with his mother in August 2018. As part of the Child Arrangement Order, which placed J1 in the care of his mother, there was to be no contact with his father without an application to court and a risk assessment by CAFCASS.

4.4 In April 2020 police attended mother's house following reports from neighbours of an assault. Mother stated that after not seeing father for nearly 12 months he had just turned up and assaulted her.

4.5 From May 2020 the police began to receive reports of concerns for the welfare of J1 in relation to mother's parenting and her inappropriate response to his behaviour. Mother stated that she was struggling to manage J1's behaviour and thought he might have ADHD. At the time she thought that her ability to cope could have been exacerbated by the Covid-19 lockdown measures.

4.6 There was Supporting Family Keyworker (SFKW) input from July 2020 – October 2020. The SFKW became the lead professional in an Early Help Assessment (EHA) following a referral from nursery indicating that J1 was underachieving in relation to his global development, and mother had expressed her view that she felt he had ADHD. Eight sessions were held via telephone due to Covid-19 restrictions.

4.7 There were further reports of concern for J1 during 2021, in relation to how mother was responding to his behaviours and also reports of J1 being left home alone and not being collected from school.

4.8 In July 2021 father 2, who is the father of mother's fifth child sibling, was released from custody and was believed to be staying at mother's address. Father 2 had a history of domestic abuse, drug abuse and violence. Mother stated that she was not in a relationship with father 2 and he would not be residing at her house. S47 enquiries were completed and a strategy meeting was held. Probation were to monitor father 2's whereabouts and report any concerns.

4.9 Around this time there were reports to the police of drug use at the address in including mother using crack cocaine. There were also reports that mother had been assaulted by father after an argument; father was pretending to be mothers brother.

4.10 There was a further period of SFKW input between Sept 21 – April 22 opportunities for observations in the home were limited due to the lack of successful home visits.

4.11 J1 was permanently excluded from his mainstream primary School in October 2021 following three incidents where J1 had used items to threaten or hurt other children. J1 started at alternative school provision on the 11th October 2021. Mother made the alternative school provision aware that she was a previous drug user and had experienced domestic violence. Mother said that there was no current involvement from Children's Social Care. However, the alternative school provision contacted EHASH after J1 presented at school with a black eye only a couple of days after being on roll, to see if the family were open to Children's Social Care and were made aware that a Child In Need Plan was in place.

4.12 In December 2021 more S47 enquiries were completed with regards to mother's substance misuse, her being physically and emotionally abusive and she was now pregnant with father 2's child, which suggested mother had not been open about this relationship. J1 was made subject to a Child Protection Plan.

4.13 At the Review Child Protection Conference (RCPC) in March 2022 it was agreed that the unborn baby would also become subject to a Child Protection Plan.

4.14 Despite being on a Child Protection Plan from December 2021 the concerns and risks posed to J1 continued to escalate. The alternative school provision were concerned that mother rarely dropped J1 off or picked him up. J1was brought into school by different neighbours and mother was often not contactable. J1 indicated he was left unsupervised to make his own food. Mother was viewed as neglectful when J1 arrived at school on 2 occasions in shoes that did not match and on two consecutive days he attended school wearing no underpants. J1 had also attended school feeling really hungry on occasion.

4.15 In April 2022 there were more reports to the police regarding concerns for J1's welfare including reports of J1 being beaten up and abused and J1 jumping out of a window. After speaking to mother and J1, officers were satisfied regarding the incident and did not believe J1 had been assaulted but were concerned regarding lack of parenting. J1 was seen with old bruises to his knees from jumping out of the kitchen window and falling off his bike. The family stated J1 had ADHD which was undiagnosed. Mother stated she punched herself in the eye out of frustration after a low-level argument with J1. Officers submitted a care plan and requested a strategy meeting.

4.16 At a strategy meeting on 22nd April it was agreed that a Child Protection Medical on J1 would be undertaken. J1 had a number of bruises on his body which maternal Aunt has raised concerns about, after seeing them on a family holiday. She had also said that J1 had said that he had drunk vodka and smoked cannabis whilst in his mother's care.

4.17 In May 2022 mother rang the police to report that J1 had stolen £1.20 from the settee and shared again that she was struggling with J1's behaviours and that she believed he had learning difficulties. J1 had been referred to CAMHS but was still waiting for an appointment. Mother said she needed some intervention as J1's behaviour was getting worse and she was scared about what he would do.

4.18 The CP Plan was reviewed and it was agreed that it did not need amending as there was no evidence to suggest the plan was not effectively safeguarding J1, however J1's behaviour remained a concern and required investigating further. It was agreed that the plan should continue however the review concluded that at that point there was no evidence to suggest J1's behaviour related to any significant abuse at home.

4.19 Mother was due to give birth in July 2022. The Midwife reported that mother had attended and engaged well with antenatal appointments, however the midwife expressed her concerns at a core group meeting, regarding the risks still posed to J1 and the number of outstanding issues on the CP Plan. The Midwife escalated these concerns to the Head of Service for the CP & Court Team and a joint meeting was convened. It was agreed that the plan was vague and needed to be rewritten and that the new experienced SW would the review plans and address concerns around engagement with mother.

4.20 Although mother engaged with antenatal appointments, after sibling was registered with the GP sibling was not seen by the GP or brought to relevant appointments.

4.21 More reports of causes for concern for J1 were received by the Police in August 2022. One caller said they heard lots of shouting and what sounded like a child being hit, then the child crying. Another caller said they could hear a child being beaten. Home visits took place and mother and J1 were spoken to. Mother explained that due to his ADHD, J1 could be aggressive and sometimes be violent towards himself and that she had been having issues with J1's behaviour for a while. No injuries were noted on J1.

4.22 Police responded to a report in September 2022 from Grandfather who said that J1 had been locked in his bedroom and that mother had not fed 2 month old sibling. On attending the home J1 answered door with mothers brother. Police found father sleeping on the settee and arrested him as he was wanted for other offences. Mother returned from shopping with sibling. Both children were found to be well with no injuries and mother said she did not know that father was sneaking in the house to use the bath and washing machine.

4.23 Grandmother also shared her concerns for J1 with the Social Care Emergency Duty Team saying that his behaviours were extremely worrying. J1 was reported to smash up the house, destroy items and it was thought he could potentially harm the baby. Grandmother shared she thought that J1 had been harmed emotionally and physically and it had been going on for some time. When mother was asked about the situation at home she said that J1 had settled now and sibling was with a neighbour when J1 was "kicking off". Mother had indicated at a core group meeting that J1 needed to be seen by CAMHS and needed medication.

4.24 In October 2022 there were several reports made by family and friends about J1 going missing. J1 was found on all occasions. On one occasion when J1 went missing mother had not reported this for 4 hours. Mother was arrested on suspicion of child neglect for failing to report this incident. Mother denied the offence and stated that she had reported the issues she had with J1's behaviour to Children's Social Care. J1 and sibling were returned to mothers care with a written safety agreement in place with mother, an Uncle and with a neighbour (family friend). The Public Law Outline process was also started.

4.25 In November 2022 the Uncle and the neighbour withdrew from the safety plan and said they could no longer withhold information regarding the care of J1 and sibling. Evidence was shared that father was staying at the house and admitting to slapping J1 over the head. It was agreed that the children should to be removed from their home but before that happened there was the serious incident at school which has led to this review.

5. The Learning

5.1 Detailed and case specific analysis is outlined below in relation to the key lines of enquiry.

Explore whether the voice of J1/J1's lived experience was captured, known and understood by professionals and how it influenced practice.

5.2 Practitioners, in particular education staff, indicated they felt they knew J1 well. When J1 first went to school mother was open about her historic drug use and the fact that she had other children who had been removed from her care. Mother could quote back to staff what she'd learned through attending parenting classes, and she demonstrated a good understanding of child development making great use of charts to aid her parenting. In short mother was capable of delivering the care J1 needed.

5.3 Primary school viewed mother as someone who was trying her best and initially observed many positives in the relationship between mother and J1. Mother was seen to be providing emotional warmth and great boundary setting; she was intelligent and had a flair for retaining information.

5.4 When J1's behaviours deteriorated this was thought to stem from early childhood experiences or potentially ADHD rather than his current experiences or new events.

5.5 Following J1's transfer, the alternative school provision shared multiple concerns between February 2022 and October 2022 which showed an increasing picture of concerns relating to neglect, alleged maternal drug misuse, neglectful parenting.

5.6 During a strategy meeting in April 2022 the following information was shared:

- Aunt visited the property and was concerned how mother interacted with J1

- J1 had fallen and cut his knee and mother did not show any affection, she blamed him for making the dog upset
- Aunt had described the house as chaotic and smelling of cannabis
- J1 was heard to be upset when his father grabbed him in the bedroom, and he cried out to be left alone
- Aunt asked if she could take J1 to her house for the holidays and mother readily agreed
- The aunt gave J1 a bath and reported that he was covered in bruising. J1 reported that his mum had given him vodka and cannabis and his dad had urinated over him
- J1 disclosed to his grandmother that he wanted to kill himself
- A police report was made by the neighbour regarding mother hitting J1, leaving him alone in the property at night and J1 telling neighbours that he was hungry
- The police visited in April 2022 and spoke to J1, he denied any abuse. When they asked about the bruise on his leg mother informed them he got it climbing out of the kitchen window as the back door was broken
- J1 had a CP medical due to the concern raised by his aunt. Doctors could not rule out his bruising was accidental, but they were concerned that he was a neglected child. A blood test was taken for any evidence of drugs or alcohol
- School reported that J1 had difficulty regulating his emotions and lacked self-esteem. Mother did not drop him off or pick him up, she relied on neighbours
- J1 was not always in full uniform and was working at a below average standard for his age group
- The unborn child's father was in prison due to weapons offenses, there was concern mother would rekindle their relationship upon his release
- The social worker manager, advised the case did not meet threshold for PLO but did for S47. The midwife challenged this decision.
- The social worker manager advised someone would visit the property later that day and if no answer the police would be contacted for a welfare visit

5.7 In October 2022 the alternative school provision reported the following concerns:

- Concerns regarding lack of adult supervision.
- J1 reported that he had been left home alone overnight.
- J1 trying to harm himself. J1 would not share what was upsetting him. Play involved themes of violence.
- J1 was out unsupervised at 10pm. Police attended. Lack of adult supervision
- J1 attending school with either 2 left feet or 2 right feet with his footwear
- A Video recording of J1 in the dark (reported to have been recorded around 7pm) sent by a neighbour to school staff. On video J1 could be heard very distressed, begging to be let back into the house, "mum please, please let me back in, I'm scared". He can be heard banging on the door. Staff confirmed to duty social worker that whilst J1 cannot be seen on the video due to the darkness it is clearly his voice.

5.8 All these incidents served to demonstrate J1's lived experience however they were too often dismissed as third party information or hearsay. Neglect was not sufficiently explored through assessments.

5.9 In contrast, once sibling was born, mother involved J1 with sibling and practitioners report loving relationships between mother and the children. This, coupled with mothers openness about her past experiences, her parenting knowledge and all round intelligence, left some practitioners in a quandary when friends neighbours and family were sharing their concerns. J1 was said by practitioners to be fiercely loyal to mother. Mother would always eloquently refute the claims; conversely mother lacked self-esteem, self-harmed and expressed feelings of shame and being overwhelmed. Practitioners reported mother was good at telling people what she thought they wanted to hear.

5.10 The voice of J1 is less evident within health disciplines. The GP only saw J1 face to face on one occasion, on the three other contacts mother was spoken to. On the one occasion J1 was seen it was noted that he was happy, smiling and playing. When mother indicated problems with J1's behaviour, requesting referral to CAMHS this was completed without the GP making an independent assessment of J1 or speaking with other professionals.

5.11 School nursing records do not evidence J1's voice. Whilst the school nurse (SN) did complete a health assessment in February 2022 this did not provide any context regarding J1's daily lived experience. The SN indicated that they had limited direct involvement with J1. Completion of strengths and difficulties questionnaire's (SDQ's) does afford SN's an opportunity to learn more about a child's lived experience. However SN's reported that whilst they do complete SDQs with parents and schools, they do not involve younger children directly as this is not as effective.

5.12 What was less well known by most agencies was the circumstances within the home. Whilst the home was clean and tidy and there was generally food available for J1, mother was not always honest and open about who was attending the home or about the nature of her relationships with either J1 or siblings fathers. The area in which the family lived was reported by practitioners to be a tightknit community where it was usual for the community to raise the children but there was often reluctance to report concerns to CSC.

5.13 When J1's father was found in mothers home she would deny knowledge that he was there and would cause confusion for professionals by indicating he was her brother. J1 did not talk about his dad; it is now believed that he had been told not to tell. Both fathers had histories of drug use and violence including domestic violence; the level of exposure to violence for J1 and sibling is not known. What is known is that a court deemed J1 was not to have contact with his father without the risk this posed being assessed. Insufficient action was taken when father was found in the home; no assessment was undertaken.

5.14 Mothers adoptive parents lived locally and mother reported a positive relationship with them. It is not known how involved they were in J1 or siblings lives.

5.15 Mother had reconnected with her birth family at the age of 21, members of her birth family are known to misuse drugs and there are blood connections between mothers biological family and father.

5.16 Mother was thought by practitioners to want to help everyone which would mean that she was open to being taken advantage of but she would equally rely on others. Two friends/neighbours would always be the ones to take and pick up J1 from school despite the fact that mother was not working. It is not known how J1 felt about this or the reason for this as this was not sufficiently explored. What developed was an co-

dependency between mother and her friends and neighbours, some of whom were known drug users and violent offenders. Mother indicated she did not understand why practitioners were concerned about these individuals being in her and, vicariously, her children's lives. Whilst some practitioners were concerned, this should have raised the level of concern across the whole partnership.

5.17 In addition, what practitioners couldn't know was that friends and family had become fearful that mother would display inappropriate behaviours in front of their own children; this prevented them challenging her. Whilst family and friends shared some concerns these were only part of their overall concerns. Unwittingly adoptive mother through supporting mother financially, potentially enabled some of mothers drug usage.

Learning point: There was the potential for J1's lived experience to be fully understood. The alternative school provision and the police actively shared their concerns with CSC. Whilst there were plans for direct work with J1 there is little evidence that this was progressed. It is also not clear how frequently J1 was seen or whether he was seen separately from his mother. During the review period two Child and Family Assessments were completed however there is no evidence that tools, designed to assist social workers understanding of children's lived experience, were used. In addition there is no evidence that the individuals who raised concerns were spoken to as part of these assessments. J1's behaviours became the focus for many practitioners, rather than exhibiting professional curiosity as to the underlying reasons for these behaviours. Mothers suggestion that these behaviours stemmed from the trauma J1 had already suffered and a possible diagnosis of ADHD were too readily accepted.

Explore whether policies, procedures and processes e.g. Did Not Attend/Was Not Brought and Responding to signs of Physical abuse/Child Protection Medicals were being followed? If not were there difficulties in doing so?

5.18 During the first period of early help, prior to the review period, mother was proactively engaged, and school confirmed good communication and engagement between mother and other agencies.

5.19 In July 2021 school were aware of two injuries to J1 in quick succession the first being a burn to a finger from the hot tap. On this occasion both mother and J1 gave corresponding accounts and medical advice had been sought. On the second occasion J1 sustained a burn to his finger and leg from dropping a lighter. The school followed policies and procedures by contacting EHASH. Accounts from mother and J1 were once again consistent but it was felt the injuries were occurring through lack of supervision.

5.20 School absences due to illness and injuries were actioned with a graduated response in accordance with school attendance policy – phone calls from administration, non-contacts were referred to Children's Welfare Officer, contact attempted via emergency contact information (extended family), home visits completed where necessary. Frequent illnesses were questioned and resulted in a referral in to the School Health Team for assessment.

5.21 Concerns as to whether there was adequate supervision, guidance, routines and boundary setting were actioned by referral to the Supporting Families Panel.

5.22 When J1 moved to the alternative school provision, staff again followed non-attendance procedures. Staff, would on occasion pick up J1 and transport him to the unit themselves. Concerns were raised regarding mothers lack of transportation of J1 but this was deemed to not be a safeguarding concern.

5.23 Whilst there were occasions when mother didn't attend antenatal appointments or the children were not brought, this never reached a level that required the use of did not attend/ was not brought procedures.

5.24 All GP appointments were initiated by mother. There were no episodes where J1 was not brought to GP appointments however, having requested CAMHS involvement, mother than failed to take J1 to any CAMHS appointments. Attempts were made to engage mother with CAMHS however, there was no consideration as to whether this lack of engagement constituted medical neglect. In addition mother did not attend some of her own appointments with the GP, which is significant. Attempts were made to follow these up.

5.25 Not all occasions when J1 was said to have been physically harmed resulted in a child protection medical.

5.26 The alternative school provision documented 5 occasions between January 2021 and November 2022 when J1 arrived in school with injuries, including three occasions when there was bruising and/or swelling to an eye, 1 with facial injuries, and 1 with marks on J1's stomach. All these incidents were reported to CSC but none resulted in a child protection medical.

5.27 A child protection medical was undertaken in April 2022, following Aunts disclosure of seeing bruising. Whilst the medical concluded that the paediatrician could not rule out an accidental cause for the bruising, nor did it conclude that the bruising could have been caused non-accidentally which is concerning. The fact that a definitive decision could not be reached seems to have reduced practitioners thinking around the potential level of risk of physical harm to J1. At the strategy meeting it was stated that the allegations were 'third party' and 'hearsay'. Reports made by extended family members need to be treated as disclosures and child protection concerns need to be discussed with the child.

5.28 The paediatrician did express concerns regarding neglect, however the reviewer notes that at the subsequent RCPC the category of risk was changed from neglect to emotional harm. Health practitioners raised concerns that the disclosures made by J1 and reports by the extended family were not being given due consideration by CSC.

5.29 Across health there were issues in accessing each other's and historic records as, at that time, records were in paper format; they are now electronic. The health visitor for sibling was unable to access any information pertaining to J1. To know J1's history would have required a trawl of the paper records which would have been time consuming.

5.30 J1 did have a relationship with his older siblings as they were in the care of mothers adoptive parents but there was nothing to link all the siblings through their records.

Learning point: There was inconsistent use of policies and procedures in relation to physical injuries with only one CP medical taking place during the period under review. Whilst policies and procedures were followed in relation to school absences this review has identified issues in relation to CAMHS appointments. CAMHS tried to engage with mother by telephone but were unsuccessful, thus there was no

opportunity to address the issues that led to the referral. Mother reported she was struggling to manage J1's behaviours and queried ADHD on many occasions, so it should have raised significant concerns when she did not respond.

Consider what actions were taken to understand the impact of mothers childhood trauma and her mental health issues on her ability to parent effectively.

5.31 Whilst mother was very open about the fact that she had been adopted and had been born to a drug user, its impact was not fully explored in assessments. The full details of mothers lived experiences were unknown. Had information pertaining to mothers history been sought this would have given practitioners greater clarity. Mother's biological father was well known in the area and had a number of children, some of whom were known to the police for drug and/or violent offences.

5.32 J1's primary school were proactive in trying to get a better understanding of mother. The school contacted drug support services and spoke with Counsellors who confirmed mother was engaged and accessing their recovery tool package. School also spoke with mothers adoptive parents who confirmed mother was reaching out to support networks. Whilst this was very positive practice less is known about the impact of mothers childhood trauma and her mental health issues on her ability to parent. No one from drug support services or the extended family were involved in any of the forums where these children/the family were discussed.

5.33 Police indicated they were not aware of mothers childhood trauma or her mental health issues as she had moved into the area.

5.34 The GP had very limited information other than to note mother had been a cared for child and adopted in March 1988. Mother disclosed to practitioners that she had Bi-polar, ADHD and a history of depression. She was taking medication for her ADHD. Mother did not attend for 4 documented GP reviews of her mental health status during the review period meaning her overall mental health remained wholly unassessed by the GP despite attempts by them to contact her. However, whilst pregnant, mother indicated there were no mental health issues at that time..

5.35 Mother was cared for under the ROMES team (Rochdale and Oldham Midwifery Enhanced Service) during siblings pregnancy. This is a specialist team of Midwives who case hold families that have complex needs and have additional knowledge in how these may impact on the mothers/ father's ability to parent.

5.36 Despite all that was known, there is no evidence that this informed practitioners interactions with mother. Currently practitioners in Rochdale are not taking a trauma informed approach when working with families. There is work being completed to take this forward.

Learning point: Historical information to better inform practitioner was not sought. As a result there was little consideration of mothers childhood trauma and mental health diagnoses on her parenting abilities. Mother was dismissive of issues that were known, indicating they were in the past. Mothers ability to demonstrate her knowledge of parenting and her confident persona impacted on practitioners feeling the need to explore these issues further. As a result practitioners were not always sufficiently curious and there was over reliance on mothers self-report with ready acceptance of mothers explanations when concerns were raised by J1, family and friends.

Consider the response by agencies to allegations of maternal drug misuse.

5.37 All agencies were aware of mothers past history of drug misuse and some did challenge mother when allegations of drug misuse were raised. However mother always denied that this was a current issue and was never seen by professionals to be under the influence of drugs. The GP was not aware of any substance abuse during the review period.

5.38 Had agencies had sight of the rich information from the previous court proceedings they would have known mother had never been honest about her drug use and had avoided testing whenever possible. Hair strand tests had always shown continued drug use which mother always denied. However, over time, mother moved from a chaotic lifestyle to a more stable situation. A view was formed that there was "little evidence to show that mother is chaotic in any substance misuse she may be partaking in currently" and as a result J1 was returned to her care. This was not the same as proving abstinence. Had practitioners been aware of this, when mothers behaviours and the behaviours of J1 deteriorated, they may have been more proactive.

5.39 Practitioners were aware that the two fathers, and some family members and friends of mother, misused drugs. Mother was asked to provide proof via a urine sample during her pregnancy with sibling but declined indicating this was in her past which was her right. Whilst this was her right, this did nothing to alleviate practitioners concerns.

5.40 The police received calls about the children on five occasions during the review period where maternal drug used was alleged; these calls were made by multiple people. Whilst these reports were always shared with CSC, they were not always shared across all partners at the time.

5.41 Following EHASH enquiries into an anonymous referral around drug misuse in July 2021, school were informed mother had denied any contact with unsuitable adults, and it was suggested that the referral had been made maliciously. It was planned that the family support worker was to work with mother to look at routines and boundaries and the functioning of the household. School saw mother start to distance herself, and J1's attendance dropped; there were indicators that routines and consistency for J1 were being impacted. Multiple friends and relatives were now taking responsibility for getting J1 to and from school.

5.42 During the Child and Family Assessment completed in July 2022 mother indicated she was using Cannabis, this was contrary to information she had previously shared; the reviewer questions whether this received sufficient exploration.

5.43 When the children were made subject to CP plans, there was an opportunity to add drug testing to the CP plan; however CSC disagreed as at that time testing had only been agreed for cases that were going into legal processes. Latterly mother was asked to provide proof of abstinence and whilst she agreed to be tested she subsequently avoided this. The lack of testing was further compounded by the stance of CSC that all allegations, even those of J1, in relation to illegal drugs were classed as 'hearsay' and minimised.

5.44 Mother continued to choose to associate with family and friends who were known to be misusing substances. It is known to be extremely difficult for former addicts to remain abstinent when they are associating with other drug users. Mothers choices needed further exploration.

Learning point: Whilst information pertaining to alleged maternal drug use was shared by partner agencies with CSC, this information was then not consistently shared across the whole partnership leaving some practitioners unaware of the police involvement with the household. Lack of conclusive evidence of drug misuse, and an overly positive view of mothers compliance, lead to disagreements and a lack of consensus across the partnership around the approach to be taken.

Is there evidence parents were deceiving or avoiding professionals? If so how aware were professionals, and what strategies did they use to circumnavigate it?

5.45 School noted a change in mothers modus operandi from July 2021. Having been very engaged, mother reduced her contact with school and J1's school attendance dropped. Policies and procedures in relation to school attendance were followed. In addition, school made phone calls to mother and the extended family, as well as visiting the family home as they had concerns around risk and felt the need to satisfy themselves J1 had been located.

5.46 Whilst there was some awareness that mother was deceiving and avoiding certain professional groups, mother was not consistent in her avoidance of services. In fact mother actively sought the support of the school nursing service for minor health concerns. At a core group in March 2022 it was identified that mother had failed to attend 3 scan appointments for the unborn baby and had kept cancelling appointments with the family worker. However in June 2022 the allocated social worker reported that mum was "doing well", engaging with her and with ante-natal services. School practitioners expressed concern that mother was not taking or collecting J1 from school, others felt this wasn't unusual.

5.47 Mother and, as a consequence, practitioners focussed on J1's behaviours rather than exploring the underlying cause. Practitioners at the practitioners event reflected that their energies had been in the wrong place. They also reflected that as one of mothers other children was open to services, there was a lot of information that could have been cross referenced; this wouldn't have been difficult to do.

5.48 There is evidence that some practitioners did raise concerns around mothers honesty regarding her lifestyle. There is evidence that mother did try to deceive police officers however officers were professionally curious and made appropriate referrals to CSC. However when J1 went missing, although police did not believe mothers version of how J1 escaped from the house, and used police powers, they accepted that CSC were working to keep the children safe and therefore did not pursue a prosecution of mother; J1 was returned to her care.

5.49 There is little evidence that full use of statutory visits was being made both in terms of speaking to J1 directly, or in observing the entire family home, this reduced the potential for CSC staff to build a trusting relationship with J1 and/or corroborate or uncover whether mother was being truthful around her drug misuse.

Learning point: There is evidence that mother and was trying to deceive professionals about her relationships with the children's fathers and her drug misuse. Whilst the police were professionally curious CSC were not. Remaining objective whilst developing or maintaining a relationship with parents is a skill. Objectivity can be assisted by managerial support and challenge. Opportunities to uncover mothers deception were missed during assessments and statutory visits. Concerns raised by

one of the partner agencies were too quickly dismissed demonstrating a lack of regard for each other's expertise across the partnership. Lack of attendance of the police in ICPC's, RCPC's and core groups prevented them communicating their experiences of mother in a meaningful way. Police are never invited to core groups but in this case involvement of an officer from the neighbourhood beat would have increased the knowledge across the partnership.

Explore the effectiveness of Child Protection/ Child in Need assessments and forums in managing risk and assessing, recognising and responding to neglect.

5.50 Mother and J1 moved to Rochdale from out of area. Whilst an assessment was completed which still identified the case as quite high risk, not all the information held was transferred. The Child Arrangement Order was discharged within months and very soon afterwards the Team Around the Family ended as the work that was required had been completed. The swift closure of the case meant Rochdale practitioners had not had an opportunity to get to know mother and the family circumstances well.

5.51 Following the two incidents of burns to J1 school were in the process of arranging a Team Around the Family meeting when concerns arose around mothers new relationship which lead to an escalation from TAF to Child in Need (CIN).

5.52 School were initially not invited to or involved in CIN meetings. J1 then moved to the alternative school provision. Over the course of eight months between September 2021 and May 2022 there were four strategy meetings in respect of J1. J1 was originally made subject to a Child in Need plan however the reviewer has not seen any evidence of a CIN plan or what meaningful actions were taken during this time.

5.53 Four months later, in December 2021, the case was escalated and an Initial Child Protection Conference held. J1 was made subject to a CP plan under the category of neglect. The reviewer has had sight of the minutes of this conference and if taken as accurate it appears the only persons present were the Independent Reviewing Officer and a Social Worker which is incorrect. The minutes do not make reference to all the concerns in relation to neglect and injuries that had been raised in the previous months and are largely incomplete. In addition there is no reference to core group membership.

5.54 Despite J1 being deemed at risk of harm through neglect, there was no plan to use neglect tools to assess this, and the outline plan does not reference drug misuse. In addition the Child and Family assessment was not shared at conference or within core groups. At ICPC it was recommended by school and the Local Authority family worker that legal advice should be sought given the history and level of concerns. CSC indicated that the threshold had not been met and that mother was indicating her intent to comply with plans; a single agency decision was made that this would not be taken forward. The IRO for this case indicated that they were new in post and that the systems and processes were not in place at the time J1's case went to ICPC. IRO's now screen ICPC referrals and the IRO is confident that if this case had been referred now it would have been flagged as needing to go to legal gateway. Legal gateway meetings are single agency meetings and whilst there is a form that is completed by the social worker, informed by information shared at core groups, partner agencies do not have any further opportunity to inform what is submitted or have sight of the information shared; this reduces their ability to challenge and understand on what basis decisions have been made.

5.55 At the Review Child Protection Conference (RCPC) in March 2022 a decision was made to make sibling subject to a CP plan following birth. Health assessments had been completed and whilst it was identified that there was a need for CAMHS involvement with J1, as there were no identified health needs for either the health visiting (HV) or SN service both stepped out of the process. CAMHS had yet to become involved with J1 meaning health in relation to J1 was not represented within core groups.

5.56 Mother, J1 and sibling were managed as if they were the entire family and whilst mothers older children were in the care of mothers adoptive parents, there was still contact and a relationship; this was not explored within assessments.

5.57 Whilst the police provided reports to the CP conferences they did not attend in person and were not party to the discussions or able to provide their expertise or further contextual information about the family members. The GP did not attend the CP conferences and were therefore unaware of any of the concerns relating to this family. In addition no agency received minutes of the meetings thus reducing the likelihood of anyone challenging any of the content of discussions. The police were made aware that the children had been made subject to CP plans but had no knowledge of what the plan contained.

5.58 Neither mothers adoptive parents, the children's fathers or family members who were supporting mothers care of J1 and sibling, were part of the Child and Family assessments or CP conferences.

5.59 Core groups were held in the family home which was seen as a positive as this afforded practitioners an opportunity to see the children and mother all together in the home environment. CSC practitioners indicated a focus on maintaining a relationship with mother. The negative side to holding core groups in the home is that this can impact on professionals feeling comfortable to challenge parents in their own environment.

5.60 The effectiveness of core groups was compromised due to a lack of attendance of key professionals or attendance by professionals that did not know the family. In addition the outline CP plan was not taken to the meeting in order to check compliance or progression.

5.61 GP's not involved in assessments, meetings and did not receive copies of the minutes.

Learning point: It is a positive that this case was escalated from Early Help to Child in Need and then Child Protection as concerns increased. Whilst J1 was not verbalising the abuse he was suffering, his behaviours were telling practitioner's that all was not well at home. This case has brought into sharp focus the importance of history and remaining vigilant to signs suggestive of abuse and neglect. Incomplete poor quality assessments, a lack of direct work, lack of use of tools to explore neglect issues, and an over reliance on self-report by mother, meant the full extent of the risks that these children were exposed to were not established. Limited involvement of statutory partners within child protection forums, reduced the partnerships understanding of the interactions between the wider family and the risks posed. Lack of understanding across the partnership of the information being shared at legal gateway is an issue that has been raised in other unpublished local CSPR's across Greater Manchester, which needs considering.

Consider whether escalation policies and supervision were used appropriately and whether there is evidence of effective managerial oversight.

5.62 There is evidence that maternity services raised their concerns at the RCPC and escalated their concerns following the meeting. As a result a joint supervision session with frontline practitioners and their managers was held between midwifery and CSC. Whilst this was good practice it is recognised that Rochdale currently have no structure to support this process.

5.63 There was clear managerial oversight within CSC however this did not provide sufficient challenge to frontline practitioners when assessments and plans were incomplete.

5.64 Whilst education staff were involved in TAF, CIN, and CP forums and provided information and opinion they did not offer any formal challenge to partner agencies or escalate there concerns when actions they felt were warranted were not taken forward e.g. the seeking of legal advice. Primary school staff indicated that the escalation of J1's case from TAF to CIN demonstrated that the heightened level of concern had been acknowledged and they therefore did not feel the need to escalate the case. The alternative school provision did verbally challenge opinions and decisions of partner agencies, however they did not follow formal escalation policies as they had been advised that legal advice was being sought and that the case was escalating into PLO.

5.65 Those disciplines who had little involvement in the CP process did not know of the concerns and therefore had no reason to escalate or seek supervision.

Learning point: Currently partnership working is not equitable. Whilst escalation processes and multi-agency supervision were sought in this case, ultimately the final decisions were made by CSC**.** The purpose of managerial oversight is to both support and challenge frontline practice and encourage wider thinking. Managers need to acknowledge the work undertake but also identify and make plans to address any gaps or shortfalls within assessments and plans. Partnership working and decision making needs to be strengthened and the multi-agency supervision processes formalised.

Is there evidence that practitioners were 'Thinking Family'? What was known regarding J1 and half sibling's father's and their wider family? How was the release from prison of both fathers managed in relation to the level of risk posed to the children?

5.66 Practitioners did have some contact with mothers extended family as it was mothers brother and girlfriend who dropped off and picked up J1 from school. In addition mothers adoptive mother also spoke to practitioners on occasion. Family Group conference was discussed as part of the CP process but had not commenced at the point the children were removed from mothers care.

5.67 Maternity services were aware of the wider family issues but what is not evident is how the impact of this was assessed and managed. Within health visiting and school nursing very little was known about the children's fathers or the contact arrangements between all of mothers children.

5.68 Mother and the children were linked within GP records however there doesn't appear to have been any consideration of wider family members other than on one occasion when concerns were raised; practice staff noted a male 'being rough and pulling mother around' in reception. Mother declined support around domestic violence

indicating it was her brother. This was not considered further when mother became pregnant with sibling, or in discussions regarding J1's behaviour, and wasn't shared with partner agencies.

5.69 With hindsight it is now clear that there was a change in mother and J1's behaviour when siblings father entered her life. Mothers denial that she was in a relationship, and a lack of clarity around the relationship left practitioners being unsure of the risks posed. J1 never spoke about either his or siblings father.

5.70 The two fathers were not involved in either CIN or CP assessments or processes, nor were family members who were known to be supporting mother and the children.

5.71 When father was released from prison this was not shared by probation with CSC thus missing an opportunity to assess the risk he might pose to mother and the children. However when father 2 was released from prison probation did flag this with CSC and make a referral.

5.72 There were signs that mother was still allowing both men into her life and, whilst some of the contact may have been unwanted, at times mother initiated the contact e.g. mother chose to pick up father up from prison, and father was found on more than one occasion at mothers address.

5.73 A significant gap in this case was police information. Police had concerns regarding possible high risk perpetrators frequenting the family home and concerns for mother as a high risk domestic violence victim and to her children. The lack of attendance by the Police in the Child Protection Review Processes meant that documentary reports were sent and this loses a dimension of being able to communicate and contribute to discussion regarding the level of risk that the fathers and others posed to the children.

Learning point: Significant information was known to both the police and CSC regarding the two fathers in this case. Assessments present opportunities for practitioners to increase their knowledge regarding children, parents and the wider family and the level of risk individuals pose. The assessments completed in this case were incomplete. Key individuals were not spoken to and are not included in terms of assessing the risk or benefits they might bring. This suggests practitioners were not sufficiently curious about the level of involvement of the fathers and the wider family in mother and the children's lives.

Consider the impact of Covid-19 on the delivery of services to the family

5.74 The pandemic did impact the delivery of services to the family. School had protocols to follow and requirements for positive test results which could have allowed mother to avoid services. Covid-19 created a challenge for school to distinguish between genuine illness and avoidance from school professionals.

5.75 Prior to the review period J1 was reported to have Covid-19 symptoms and/or had been in contact with a positive case. On one occasion there was a class bubble closure and J1 failed to return when the isolation periods were over. All absences from school required the child to be tested for Covid-19. Concerns were hi-lighted with parent and a referral to school health was completed.

5.76 In the period of this review J1 presented at school ill and mother was contacted to collect and take home.

5.77 Covid-19 impacted the work of the SFKW. During the first period of SFKW input prior to the review period, there was a national lockdown and restrictions. This resulted in

no face to face work taking place and sessions being undertaken in a virtual way using skype video calling and teams. This impacted on the direction that work took and led to the focus becoming J1's behaviour, potential ADHD and linking in with CAMHS. Opportunities were missed at this point to really work with mother and understand how her past experiences were shaping her parenting and her relationship with J1 following their period of separation whilst he spent time in foster care.

5.78 Families receiving Early Help services during restrictions, were assessed in terms of need to determine whether interventions were offered virtually or via doorstep visits. SFKW's were consistently available, and in this case there was no change in allocated workers during either episode of involvement.

Learning point: Covid-19 did impact on services work with this family. Direct work was reduced and practitioners became over reliant on mothers self-report. Enforced reduction in face to face contact made it difficult for practitioners to establish whether there were genuine reasons for non-attendance or whether there was avoidance of services.

6 Good Practice

- There is evidence of a positive response from all agencies when J1 became acutely unwell.
- A school based family worker was allocated to provide parenting advice and support to mum after the local authority family worker withdrew due to non-engagement.
- Direct supervision was sought from the school nurse from the safeguarding team and advice and support offered. The safeguarding children team and midwifery safeguarding team evidenced shared concern and professional challenge where concerns had been escalated by the midwife in the first instance which resulted in a meeting between social care manager and named safeguarding professionals followed up with multiagency safeguarding supervision.
- Information sharing from Midwifery services to health visiting service following birth of sibling and subsequent contact by HV to social care.
- Maternity services recognised the risk of substance misuse and referred the unborn to CSC as soon as risks were identified.
- Strategy meetings included a wide range of services and were well attended.
- Maternity services participated in professionals' meetings and raised. concerns that mother was not being open and honest regarding her lifestyle.
- SFKW visited school to meet J1, Pictures J1 drew during discussion are uploaded in documents. Age appropriate tools were used to support J1 during sessions.
- Communication between the SFKW & the SW was a constant 2 way process.
- The case escalated from EH – CIN – CP during the time that SFKW was involved indicating communication and working together was taking place.
- GMP officers tried to engage well with J1 to listen to his responses and to understand his lived experience. The officers have taken the child away from

the adults to speak alone with him to allow the child to express any concerns without being afraid of his mother overhearing him which was a positive action to take. The officers have tried their best to find interesting ways to engage with him and to gauge whether there are any concerns, like playing on his bike outside and letting him sit and play in the police van which is good practice.

- The alternative school provision worked tirelessly to support J1 and alert partners as incidents and concerns arose.