Milton Keynes

Multi-Agency Child Safeguarding Practice Review

Child ‘F’

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1. Introduction

1.1 In May 2019 Milton Keynes Safeguarding Children Partnership commissioned a multi-agency child safeguarding practice review[1] in respect of a child aged 2 and a half years old who fell from his first-floor bedroom window and sustained potentially life-threatening injuries. An investigation into the accident found that there were no suspicious circumstances and the child, to be known as F, subsequently made a full recovery.

1.2 It was recognised that there was potential learning from this case in the way that agencies work together to safeguard children in Milton Keynes. The National Panel were informed of the review.

2. Process

2.1 This report has been written with the intention that it will be published, and only contains information about F and the family that is required to identify the learning from this case.

2.2 The review considered single agency reports and relevant records and assessments. The independent author met with practitioners and senior managers to discuss the case[2] and identify opportunities for practice improvement. All who participated in the review had an opportunity to comment on the draft report and information shared informed the learning and recommendations.

2.3 The review considered multi agency practice during the two years prior to the incident when F fell from his bedroom window. This included two periods when F and Sibling 1 were subject to Child in Need Plans (CiN). Relevant information beyond this timescale also contributed to practice learning.

2.4 Mother, maternal grandmother, and the Father of Sibling 1 were invited to participate in this review, however at the time of writing this report the family have not been involved[3]. Efforts to engage the family are ongoing and it is acknowledged that the contribution of family members will strengthen multi-agency learning within this review. Currently there is limited understanding about how the family, particularly Mother experienced multi agency support during the timeline considered by this review.

3 The Family and background information

3.1 F lived with his Mother and Sibling 1 who was 8 years of age at the time of the incident. Sibling 1 had regular contact with her Father (Mother's previous partner) who lived in a different local authority. Maternal grandmother offered support to Mother and will be referred to as MGM. F's Father did not live with the family and there was a history of domestic abuse between Father and Mother.

[1] SCRs have been replaced by child safeguarding practice reviews which should be considered for serious child safeguarding cases where: abuse or neglect of a child is known or suspected, and a child has died or been seriously harmed. https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

[2] There was a meeting with managers in January 2020 and virtual meetings were held with practitioners in July 2020 due to Covid-19 restrictions.

[3] The family has since moved to a different local authority, letters with information about the review were sent via recorded delivery.

3.2 Mother has a history of mental health difficulties and substance misuse and has been known to Central and North West London (CNWL) Mental Health Services since October 2012. Mother regained custody of Sibling 1 in 2015 following a period when Sibling 1 lived with her Father.

3.3 Mother was referred to MK-Act[4] by Thames Valley Police (TVP) in 2015. She initially showed interest in the Freedom Programme, however she did not engage. In July 2016 Father of Sibling 1 contacted Children's Social Care to report bruising to Sibling 1, allegedly caused by Mother[5]. A strategy meeting was held and Child and Family Assessment (C&F) completed for unborn F. The assessment highlighted concerns about domestic abuse from BC[6] and noted legal action will be sought if it becomes known to CSC that Mother and Father are having contact. Additional concerns included: Mothers mental health, alcohol misuse and unknown males visiting the home address. The case was closed to CSC and transferred to Children and Family Practices (CFP).

3.3 In July 2016 School made a referral to CSC and reported that Mother was asking other parents for money to pay for electric. The recorded outcome was that school were to speak with Mother and the contact was closed to CSC. School made a further referral to CSC in September 2016 to report bruising to Mother and concerns about the cleanliness of Sibling 1[7].

3.4 When he was 2 weeks old F was admitted to hospital due poor weight gain. It was recorded that ward staff noted that mother was unkempt, and her clothes were unclean. Support of the CFP team and Health Visitor was identified prior to discharge. Mother was also given advice about appropriate dress as F appeared to be too warm.

3.6 In March 2017 a further referral was made by School to CSC. A third party alleged that Mother had asked parents for money which was used to buy cannabis and expressed concern about the welfare of F. Mother denied buying drugs and it was recorded that the case was closed following enquiries as CSC had identified no concerns.

3.7 During 2016 and 2017 there were eight reports to Children's Social Care (CSC) from TVP regarding domestic violence between Mother and Father. In May 2017 CSC received a referral from the Probation Service with concerns about Father living with Mother in breach of a Restraining Order, sharing his methadone prescription with Mother and misuse of Class A drugs. Father was arrested for breach of the Restraining Order and Harassment and a Community Order was extended for six months due to non-compliance. A vulnerability assessment completed by the Police identified that there was a risk of neglect and this information was shared with CSC. At this time MGM also raised concerns about the care of F with CSC and said that he was coughing badly and unclean.

4 **Agency involvement June 17 - May 19**

4.1 The following services were involved with the family:
Children's Social Care (CSC)
The Police (TVP)
School
CNWL: Health visitor, mental health services, school nurse
Chronology of key activity

[4] MK- ACT is the specialist domestic violence service for Milton Keynes, commissioned in 2008 by Milton Keynes Council and managed by Milton Keynes Women's Aid.
[5] TVP and CSC conducted a joint visit and it was reported that Sibling 1 said that Mother and Father (of F) had pulled her by the arm and Mother pinched her tummy.
[6] BC was subject to a restraining order and Mother consistently denied that he was the Father of F
[7] Sibling 1 was very dirty and teaching assistants wiped her body down, she also had red spots and was itchy.

Date	Event	Agency
June 2017	Police attended the home of F following a third party report that a male and female were arguing. Mother denied there were any concerns, F was present. Police made a referral to CSC. A Child and Family assessment was completed and the children were made subject to CiN plans. Health Visitor (HV) unannounced home visit, no access, saw male upstairs, informed CSC	TVP CSC Health Visitor
July 2017	Social Worker (SW) attempted an unannounced visit. SW contacted TVP to discuss welfare check following sighting Mother with a male thought to be Father of F.	CSC TVP
October 2017	School reported that Sibling 1 was hitting her head when frustrated. Signs of Safety mapping meeting	School/CSC CSC
November 2017	Written Agreement between CSC and Father due to risk of domestic abuse.	CSC
December 2017	CiN closed. School Nurse advised the SW that Sibling 1 had not been brought to health appointments and was informed by Social Worker that the CiN case had been closed. Father of Sibling 1 made a referral to CSC with concerns about the welfare of Sibling 1. Sibling 1 made a disclosure to SW about Mother's drug use. A Child and Family assessment was completed and the children were made subject to CiN plans. A safety plan was put in place.	CSC School Nurse CSC
January 2018	PGM informed the SW that Mother arrived to her home under the influence of alcohol with F in the early hours of the morning and said that she had been with Father. Mother received a letter from school regarding the poor attendance of Sibling 1.	CSC School
February 2018	Children's Social Care contacted the Mental Health Specialist Therapies Team following a report from Father of Sibling 1 that Mother was taking illicit substances in front of the children. The Mental health practitioner reported there was no evidence of Mother using alcohol or illicit substances at the time.	CNWL

April 2018	CiN closed. Mother received a second letter from school regarding the poor attendance of Sibling 1 School made a referral to CSC noting third party concerns that Mother was asking for money and associating with drug users.	CSC School CSC
June 2018	Mother reported to be asking other parents for money. Information was shared with CSC. Mother received a warning letter from school regarding the punctuality of Sibling 1	School/ CSC School
September 2018	Anonymous allegation that Mother is using drugs expressed concern about the welfare of the children.	CSC
October 2018	School logged a concern with CSC about the appearance and smell of Sibling 1.	CSC/ School
November 2018 November 2018 – April 2019	Health visitor unsuccessful in attempts to arrange the 2 year developmental assessment for F. Mother attended 7 out of 14 sessions with the Specialist Therapy team (STT).	HV STT
December 2018	Anonymous referral stated that Mother using and buying drugs. Anonymous call to TVP regarding Mother using and buying drugs from house – information was shared with CSC with a view that they should lead any follow up enquiry.	CSC TVP
January 2019	Out-of-hours notification received from MK Urgent Care. F had fallen from his highchair, and hit his head on a wall – sustained a left side v-shaped partial thickness wound. Wound cleaned, and glued. Attended with Mother and MGM. Parent informed School that mother was in town begging with Sibling 1 – Mother denied this and said that Sibling 1 was at home unwell. Teacher spoke to Mother as F was seen shivering in pushchair. Mother advised this was normal.	Health Visitor School School
March 2019	Mother received a third letter from school regarding the poor attendance of Sibling 1.	School
May 2019	F fell from bedroom window on first floor.	

Analysis

5.1 Guided by the Terms of Reference for this Review[8] and following analysis of the available information, the following areas were identified as opportunities for practice improvement:

- Multi-agency response to domestic abuse, parental mental health and substance misuse
- The CiN process
- Understanding the lived experience/voice of the child
- Multi-agency information sharing and response to concerns raised

Multi-agency practice is discussed below and key learning points are identified at the end of each section. Some information is relevant to more than one area and care has been taken to avoid repetition.

Multi agency response to domestic abuse, parental mental health and substance misuse

5.2 Prior to the timeline for this review there was evidence of domestic abuse between Mother and Father of F. Significant concerns about their relationship were highlighted in Police records. Father had been arrested for breach of a restraining order and Probation had shared concerns about ongoing contact between Mother and Father of F.

5.3 A Child and Families Assessment completed in September 2016, before the birth of F noted the potential risk to the children should Mother continue to have contact with Father. In response to concerns that BC was the Father of unborn baby F it was noted: *if this was true Children's Social care would have serious concerns and would seek child protection and legal advice to safeguard Unborn F* The assessment also noted that: *Mother said she has not breached the Child arrangement order and said she is not pregnant by BC.*

5.4 There were two occasions within a 6 month period when concerns regarding domestic abuse and substance misuse were highlighted. There were shortcomings in decisions made to safeguard the children and missed opportunities to provide effective support and intervention. This review has identified opportunities for multi-agency learning regarding: assessment of risk, understanding of Mother's ability to parent and response to cumulative risks of harm; each will be discussed in turn.

Assessment of risk

5.5 In June 2017 Police attended an incident at Mother's house following a third-party report of a male and female arguing. The Police report noted that this was not the first occasion both parties (Mother and BC) had ignored a restraining order that was in place at the time. Mother refused to cooperate with a domestic abuse risk assessment and denied that BC had been present; a referral was made to CSC. The CSC report completed for this review noted that following a Child and Family assessment and child protection consultation a decision was made that the children should be made subject to Child in Need Plans. The rationale provided for this decision was that: *the social worker had only recently been allocated the case and a suggested plan was put in place by the Independent Chair.*

5.6 It is questionable whether the decision to implement CiN plans was appropriate or proportionate at this time. There was evidence of persistent domestic abuse and lack of

[8] The TOR included: exploration of multi-agency support to families experiencing domestic abuse and substance misuse and identification of and response to neglect.

engagement by Mother who had consistently denied that she was associating with BC, who was subsequently confirmed as the Father of F. These concerns met Level 4 on the MK indicator of need: *SPECIALIST NEEDS: Children with complex and enduring needs which cross many domains*.

5.7 Significant efforts were made by the social worker to engage both Mother and Father in the CiN plans between June – December 2017. The Parents were made aware of the concerns relating to domestic abuse and there were clear expectations about their responsibility to safeguard the children. A Family Mapping meeting took place prior to closure of the case to CSC and it was recorded that: Mother had been in contact with Father and also allowed him to have contact with F. Professionals had concerns about the safety of the children should there be further incidents of domestic abuse. However, there was multiagency agreement to close the first period of CiN as Mother was reported to be engaging with services, a support plan was in place and improvements had been made.

5.8 Ten days after closure of the initial period of CiN, Father of Sibling 1 made a referral to CSC with concerns about the welfare of Sibling 1 and an allegation that Mother was taking drugs. A management decision was made to undertake a Child and Families assessment to explore the concerns further. A safety plan was also put in place which clearly explained the expectations of Mother in order to safeguard the children. This was signed by Mother, the SW and manager of the team. The CSC report prepared for this review noted that this was an appropriate decision: *as a Child & Families Assessment hadn't been completed recently and the concerns raised had been a previous concern for CSC..... the decision made to remain on a CIN plan was appropriately evidenced within the analysis, including the use of MK Levels of Need threshold. ....it was agreed to keep at CIN because drug and alcohol testing had not taken place and that would mitigate the risk.*

5.9 There appears to have been authorisation for a further period of monitoring, checking out with Mother and additional assessment. It was evident that there had been a long history of concerns regarding domestic abuse between Mother and Father with additional concerns regarding substance misuse and Mother's mental health. Child and Family assessments had been completed in September 2016 and June 2017 and concerns were discussed at the Family Mapping Meeting in October 2017. There had been multi agency exploration of concerns within the CiN process and expectations of Mother and Father had been made clear in written agreements.

5.10 The management of risk in this instance does not appear to be robust and is consistent with observations within the 2016 Ofsted Report which noted that: *The local authority's approach to family support, working with some families about whom there are safeguarding concerns via a structured problem solving approach without escalating the intervention into the child protection conferencing system, needs to be strengthened to ensure that risk is managed effectively*[9]*.*

5.11 There was no evidence that consideration had been given to escalate the case given the repetition of concerns regarding domestic abuse and substance misuse. The decision to further explore concerns and remain at CiN for a second period was not sufficiently robust or proportionate to safeguard F and Sibling 1. The Child and Family Assessment recommended that: *Mother to complete a set of drug tests, Mother to contact the police whenever Father tries to contact her and Mother to discuss with her key worker her feelings about alcohol*[10]*.*

[9] https://files.ofsted.gov.uk/v1/file/50004351

[10] Record of Strategy meeting 21.5.19

5.12 The pre-birth assessment for F, which suggested seeking legal advice to safeguard the children should Mother and BC be in contact, appears to have been disregarded. The risks for children who are exposed to domestic abuse are well recognised however there was little evidence that the physical and emotional wellbeing of F and Sibling 1 was central to work of professionals, specifically within the second period of CiN. The focus of professionals appeared to be on Mother and her needs and the lived experience of F and Sibling 1 was not consistently prioritised.

5.13 The 2016 Triennial Review of Serious Case Reviews noted that: *Where risks are identified which do not appear to meet the threshold for children's social care involvement, there may be little analysis of risks of harm. Support plans may be unclear and can easily drift*[11]. Information provided to this review suggests that the analysis of risk was inadequate given the information that was known to agencies regarding domestic abuse, substance misuse and parental mental health. In addition, there was little evidence that Mother was able to sustain change and effectively safeguard F and Sibling 1.

Understanding of Mother's ability to parent

5.14 A parenting assessment was not completed therefore practitioners did not have clarity about the capacity of Mother to safeguard F and Sibling 1. Mother had experienced many years within an abusive relationship and there were ongoing concerns that Mother was vulnerable, had not always recognised the risks posed by Father and had at times prioritised contact with Father over the safety of the children. The complex interplay between mental health, substance misuse and domestic abuse and the impact on Mother's parenting and ability to sustain engagement with service does not appear to have been fully considered within assessments. Practitioners noted that the concerns about Mother's parenting capacity had not been significant enough to warrant a specific parenting assessment and MGM was perceived to be a significant protective factor by all professionals.

5.15 The 2016 Triennial Review of SCRs highlighted that:

> *A tendency for professionals not to consider mental health issues in the context of parenting capacity, means that a full understanding is not reached, and potential risks to children not identified (p233)*

5.16 There was consensus among practitioners that the case may have escalated to child protection had MGM not been involved. However, the relationship between Mother and MGM was not fully explored. Mother was initially resistant to inform MGM that CSC were involved with the family and she told the Mental Health practitioner that she felt stuck as MGM was controlling her finances and school were liaising with MGM rather than herself regarding the children. There was inconsistency in the professional perception of MGM as a protective factor. On occasion School checked out concerns with MGM rather than Mother as MGM was considered to be a significant protective factor. However, at the strategy meeting in May 2019 it was recorded that School reported that MGM could at times be *'defensive and try to hide a problem rather than face it'* Practitioners stated: *'It was difficult to pick out what were the concerns and difficulties in the relationship between Mother and MGM'.*

Response to cumulative risks of harm

[11] Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014. Sidebotham, Peter et al. Department for Education, 2016 p242

5.17 Domestic abuse, parental mental health and substance misuse featured strongly throughout this review however each referral and additional concern appears to have been addressed as a single issue. The underlying context of vulnerability and risk was not fully assessed and the cumulative risk of harm does not appear to have been recognised. The C&F assessment completed in December 2017 did not include a chronology. Without a chronology the pattern of repeated concerns may not be fully recognised and risks may not be understood. A chronology enables practitioners to have comprehensive picture of the child's life and reduces the risk of viewing each incident as a single episode. The cumulative factors of domestic abuse, parental substance misuse and mental health problems are known to present significant risk factors for children. Domestic abuse, in particular, has featured within SCRs as one of a set of harmful parental behaviours that increases the risk of significant harm to a child[12].

5.18 Following the closure of the second period of CiN there were regular reports shared with CSC by members of the public or via school with concerns about the welfare of the children and allegations of parental substance misuse. In September 2018 a duty social worker liaised with School, Health and Mother prior to closing a referral. It is unclear what information was shared to inform this decision as in the preceding months School had raised a series of concerns which included; Mother asking parents for money, associating with known drug users and poor school attendance[13] of Sibling 1.

5.19 In December a further anonymous referral was made to the Police and CSC. It was recorded that: *CSC received another report from an anonymous neighbour, that Mother had been seen buying heroin from a car and drug dealers were seen going into the home. Checks were not re-done but Mother was spoken to and if any further concerns were received another C&F assessment would be completed.*

5.20 The Police report concluded that there should have been a more formalised response by the Police to the referral via either a Child Protection report or intelligence submission that could have led to a review within the Multi Agency Safeguarding Hub (MASH). The decision not to attend was based on a misunderstanding about whether the children were at the property and an inaccurate observation that the last child protection report was in 2014, when in fact, Police had raised child protection concerns in a report following a domestic incident in 2017.

5.21 The decision to close the referral in December 2018 without additional exploration appears to have been an inadequate and inappropriate response to serious concerns. It seems that there was a tendency for Professionals to assess the referrals and information shared by anonymous third parties as malicious. It is possible for information provided in bad faith (maliciously) to be partially or completely accurate however there was limited evidence that consideration had been given to the factual accuracy of referrals that were considered to be malicious.

5.22 Between December 2018 and April 2019 Mother's attendance at the Mentalization Based Therapy (MBT) group was irregular. Mother reported feeling unsettled and spoke openly about her relationship with Father and shared significant anxieties about extracting herself from the relationship. In January 2019 Mother reported that Father was turning up at her house more frequently. In March 2019 Mother reported that she felt anxious about Father's reaction following the pending house move. This information was not shared with CSC or other

[12] Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014. Sidebotham, Peter et al. Department for Education, 2016 p238

[13] Sibling 1 visited her Father in a different local authority at weekends and some of the attendance concerns were due to Sibling 1 not returning in time for school on a Monday mornings

professionals. There appears to have been little consideration about how the relationship between Mother and Father impacted on the children.

5.23 The MH practitioner stated that Mother was advised to contact the Police if Father of F showed up at the house however it was acknowledged that Mother did not do this. Practitioners stated that Mother appeared to be more able to manage her mental health constructively and there was a sense that Mother was better able to manage herself and safeguard her children than in previous years. The positive assessment of Mother's progress was shared by practitioners in CSC when reflecting on the closure of the second episode of CiN.

5.24 Whilst the assessment of these practitioners may have been accurate there was no clear evidence to suggest that the risks to the children with regard to domestic abuse, substance misuse and parental mental health had significantly reduced. It was not possible for practitioners to have confidence, from the information available to them that F and Sibling 1 were effectively safeguarded.

5.25 The Health report noted that: *Mental Health Practitioners need to be able to pick up on some of the subtle comments that are shared, and how this may be impacting on the children's lives, and Mother's ability to effectively parent. Also, to feel confident in escalating to partner agencies to ensure that they are also aware of any given situation.*

5.26 The multi-agency response to concerns about domestic abuse did not appear to fully consider the case history, specifically information contained in the pre-birth assessment for F. Ongoing concerns about domestic abuse, substance misuse and parental mental health were noted throughout the timeline for this review. In the absence of a parenting assessment it was not known whether Mother had the capacity to protect F and Sibling 1. Given the persistence of these concerns and the vulnerability of the children it would have been appropriate for an ICPC to be convened during the period considered by this review. The 2016 Ofsted report noted that: *Management oversight of child in need plans is insufficiently robust. In some children's experience there was a lack of timely progression to child protection enquiries when risks had increased.* From information provided to this review this was the experience of F and Sibling 1.

5.27 Practitioners acknowledged that F and Sibling 1 will have been impacted by their experience of neglect, domestic abuse and the substance misuse of Mother. At the conclusion of this review, it was unclear how or whether the support and intervention provided by agencies had resulted in a significant and sustained improvement in their lived experience.

Learning Point 1

When there are concerns about parental mental health, substance misuse and/or domestic abuse it is important that practitioners understand how these difficulties interact within the family and this information informs assessments and decisions to safeguard and reduce the negative impact on the children.

Learning Point 2

When there are concerns about parental mental health, substance misuse and/or domestic abuse, a holistic multi-agency assessment is required to consider historical information and provide clarity about outcomes and escalation should concerns persist, in order to prevent drift and provide adequate safeguards for children.

Learning Point 3

When parents are involved in mental health services it is important that there is transparency between practitioners and parents about information that will be shared with partner agencies, to inform the provision of support and intervention to safeguard children.

The CiN process

5.28 During the timeline for this review F and Sibling 1 were assessed as requiring support and intervention at the level of Child in Need[14] on two occasions. The Milton Keynes level of need document notes that this is level 3 for: *Children whose needs are more complex. This refers to the range, depth or significance of needs. More than one service often needed, with a 'Team around the Family' and Lead Professional. Children and Families Practices often involved.* This part of the review will focus on the CiN process, discussion about whether it was proportionate to assess long standing concerns regarding domestic abuse at level 3 was provided in the previous section.

5.29 Working Together 2018[15] notes that: *a child in need is defined under the Children Act 1989 as a child who is unlikely to achieve or maintain a reasonable level of health or development, or whose health and development is likely to be significantly or further impaired, without the provision of services; or a child who is disabled. Children in need may be assessed under section 17 of the Children Act 1989 by a social worker*

5.30 There was a period of 10 days between closure of the first CiN plan and opening of the second. It is important to highlight that significant efforts were made during the first period of CiN to involve the family and communicate with partner agencies and this is included as good practice within this review. The social worker liaised with Father's probation officer, and attended an appointment to discuss the CiN plan[16] in an attempt to involve Father in the CiN process. The social worker also encouraged Mother to tell MGM about the involvement of CSC so that additional support could be provided by MGM.

5.31 This review has highlighted opportunities for learning about the importance of having consistent agency records, and shared understanding between practitioners about CiN plans, decision making with regard to closure and multi-agency information sharing during the CiN process.

5.32 The authors of the agency reports for CNWL and CSC presented differing assessments about the quality of plans for the first period of CiN. The Health report noted that: there was more focus on the needs of Mother and lack of consideration about the health and developmental needs of F and Sibling 1. In contrast the CSC report noted that the plans were clear, detailed and focussed on concerns at the time with realistic and achievable actions.

5.33 Development of the CiN plan is a multi-agency activity and it is important that professionals work proactively to ensure that Plans are child focussed and address all the needs of a child including health and development. There is an opportunity for practitioners from all agencies to suggest amendments to the CiN plan at the statutory CiN review meetings.

[14] https://www.mktogether.co.uk/wp-content/uploads/2019/05/fv_MKSB-Levels-of-Need_April-2019.pdf

[15] During the time period under review statutory guidance Working Together 2015 was revised and Working Together 2018 was published.

[16] Father of E did not attend this appointment

5.34 There was inconsistent understanding between professionals within CNWL and CSC regarding the closure of the first period of CiN and ongoing support to be provided by agencies. The CSC report noted that: *A clear explanation of why CSC were closing the case is recorded, alongside a plan of who was still involved and offering support.* Practitioners acknowledged that there was multi-agency agreement to close the case due to the positive involvement of Mother and the provision of support by agencies. The social worker with responsibility for the first period of CiN informed the review that at the end of the first period of CiN the plan was that Mother would take F to the clinic once a month and this was to be monitored by Health.

5.35 At the practitioners' event Health professionals stated that the information about closure following the first period of CiN was that Mother would contact the Health Visitor every three months. There were no formal closure records shared with Health and this information was contained within the notes of the HV taken at the meeting. It is important that practitioners share a consistent understanding of the support to be provided by each agency and clear expectations of parents/carers, to enable effective monitoring of progress and timely identification of unmet needs.

It was acknowledged by all practitioners that when the CiN plans were closed Mother disengaged with services and it was a challenge to monitor the wellbeing of F. The Health report noted that: *Following closure of the CIN Plan health visitors need to ensure continued monitoring of child's health and development and see non-engagement as a cause for concern to be actively addressed to ensure safety and welfare of the child.*

5.36 The review has found that the system for informing School Nurses about closure of CiN plans requires strengthening. CSC records reflect that an email was sent to the School Nurse to advise of closure. However, when the School Nurse contacted the Social Worker in December 2017 regarding Mother not taking Sibling 1 to Health appointments, she was unaware that the CiN plan was no longer open. At the learning event practitioners noted that there appears to be a more robust process to record episodes of CiN in children under the age of 5 years, as opposed to those of school age. It is possible that the information about closure had been sent to a personal email and this was not uploaded onto the general system. It is unclear if any action was taken regarding the information shared about Sibling 1 not being taken to health appointments.

5.37 Health professionals involved in this review noted that Health colleagues were not informed about or involved in the second period of CiN. There was limited information within agency reports to reflect multi-agency working with health during the second period of CiN. This highlights a significant omission and opportunity for learning, particularly as closure of the initial CiN plan relied on support being provided by the Health Visitor.

5.38 The CSC report noted that *during the second period of CiN concerns were listed in the plan under parenting capacity rather than child's development or family and environment.* At the learning event practitioners noted that some of the CiN plans could have been more robust. It is recognised that clear, child focussed multi-agency plans are central to effective working at the level of child in need and child protection. It appears that the child in need plans for F and Sibling 1 lacked detail at times with regard to specific actions, expected outcomes and consequences should the risks not reduce. The 2020 triennial analysis of SCR's[17] noted that:

[17] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/869586/TRIENNIAL_SCR_REPORT_2014_to_2017.pdf

Good planning with key objectives and milestones identified also provides a means of measuring and monitoring progress. This is as important in 'child in need' planning as in child protection as the plan provides an opportunity to identify when interventions are failing and escalation is required (p110).

5.39 Closure records of the second CiN plan did not evidence that the initial concerns regarding Mother's ongoing contact with Father had been fully addressed and the required actions completed. There was lack of evidence within the closure summary that Mother had completed required drug tests which were initially identified as necessary to identify and reduce the risk to Sibling 1 and F. At this time there was a change in the service level agreement between CSC and Substance Misuse Services to undertake drug testing when there were concerns about the substance misuse of parents/carers. Practitioners stated that the change required completion of request forms for drug testing which were costly and not as responsive.

5.40 Whilst there was some good multi-agency communication and coordination when the children were subject to CiN plans this was not sustained. Agency records indicated that there was inconsistency in the understanding of professionals about the support needs of the family following closure of the CiN plans. This contributed to lack of monitoring and limitations in information sharing.

Learning Point 4

The lived experience of children and young people will improve when multi agency CiN plans are child focussed with clear actions and measurable timely outcomes.

Learning Point 5

It is important that there is a shared understanding between agencies and the family about the roles and responsibilities of practitioners to implement the CiN plan, with specific focus and clarity about the provision of support on closure to monitor progress and sustain change.

Learning Point 6

Effective multi agency information sharing regarding the risks and vulnerabilities of children and young people should inform assessments and decisions regarding the provision of support and intervention and prevent drift and delay in meeting their needs.

Understanding the lived experience/voice of the child

5.41 Examples of good practice in listening to the voice of the child and understanding the lived experience of F and Sibling 1 were noted during this review. The CSC report reflected that during the first period of CiN, Sibling 1 was seen regularly in different settings and various tools were used to support the exploration of wishes and feelings. Observations of F were recorded following home visits. The report stated that: *The case notes clearly evidence the voice of the child.* However practice was at times inconsistent and it was noted that agency records did not always reflect the children's voice and assessments could have included more information with regard to the lived experience of the child.

5.42 During the timeline considered by this review factual observations were recorded by agencies which gave cause for concern about the care provided to Sibling 1. In October 2018 Sibling 1 attended school very dirty and smelling of urine on a number of occasions. Sibling 1 was also

uncomfortable getting changed in front of others and wished to get changed in the toilets. On one occasion Sibling 1 was reported to be banging her head in frustration at school.

5.43 School had made previous reports with significant concerns about the cleanliness and hygiene of Sibling 1. There was no evidence to suggest that the impact of being unclean on the emotional wellbeing of Sibling 1 had been considered. Whilst professionals spoke to Mother about the concerns and recorded their observations there appeared to be lack of multi-agency consideration about whether Sibling 1 and F were subject to neglect.

5.44 Professionals recorded their observations of F during the CiN process and Children & Families assessments. However, F was not seen by professionals for over a year prior to the incident and Mother disengaged with agencies following the closure of the second CiN Plan. The Health Visitor had been unable to arrange the 2 year development check with Mother prior to the incident and this would have provided an opportunity to further understand the lived experience of F. The CNWL report noted that: F *was only seen once in Jan 2018, and not again prior to the incident. Behaviour and demeanour would have given the Health Visitor important information about the child.*

5.45 During the period considered by this review three letters of concern regarding the attendance and punctuality of Sibling 1 were sent to Mother. It is known that non-attendance at school is a risk factor for children and a potential indicator of unmet needs. Whilst there may have been improvements once concerns had been addressed with mother these were inconsistent and change was not long term. There appeared to be an absence of multi-agency discussion about how best to sustain change and improvements that would impact on the life of Sibling 1. Long term unmet needs have a significant impact on the life opportunities of children and it is important that non-attendance at school is recognised and addressed as a significant risk factor and potential indicator of neglect.

5.46 In the months prior to the incident there were a number of anonymous calls to CSC with a range of allegations about Mother which included: acquiring drugs outside the house, associating with known drug users, asking parents for money and begging with Sibling 1 in town. The callers also reported concerns about the wellbeing and cleanliness of E and Sibling 1. Whilst the factual accuracy of the allegations and concerns was often checked with Mother there was limited evidence within agency records that the impact of these allegations on the lived experience of F and Sibling 1 had been discussed.

5.47 Whilst professionals had regular contact with Sibling 1 and some contact with F work was not conducted in a way that was consistently child focussed. There was lack of multi-agency consideration about how the concerns regarding adults impacted on the lived experience of the children/voice of the child. Information was known however it is unclear about how or whether this informed multi agency practice. Understanding the lived experience of the child is a complex process and listening to the voice of the child is well recognised as the cornerstone of effective safeguarding practice.

5.48 The importance of professionals having a child centred approach is well recognised and listening to the voice of the child has emerged as key learning in SCRs[18]. The Children Act 1989 requires local authorities to give due regard to a child's wishes when determining what services to provide.

[18] The voice of the child: learning lessons from serious case reviews. Ofsted 2010

5.49 From the information considered by this review it appeared that there was limited multi-agency consideration given to understanding the lived experienced of F and Sibling 1. Whilst agency records reflected the 'voice of the child' it was unclear how or whether this information influenced decision making or multi-agency practice specifically in response to ongoing concerns about the wellbeing of the children.

Learning Point 7

It is insufficient to record concerns about school attendance, personal hygiene and the general well-being of children, it is important that appropriate tools are used to monitor and assess whether unmet needs and vulnerabilities are risk factors for neglect

Learning Point 8

It is important that professionals are supported to critically reflect on observations of children and young people to further understanding their lived experience, and identify support to improve the wellbeing of children and young people particularly when there are concerns regarding neglect.

Multi-agency information sharing and response to concerns raised

5.50 Working Together (2018), notes that:
Effective sharing of information between practitioners and local organisations and agencies is essential for early identification of need, assessment and service provision to keep children safe[19].

Missed opportunities to record, understand the significance of and share information in a timely manner can have severe consequences for the safety and welfare of children. This review has identified that at times information sharing could have been more robust between agencies and practitioners. In addition, agency records and the response to referrals/concerns raised indicated that the significance of information shared was not always understood by practitioners.

5.51 In July 2017 the social worker contacted the police[20] following a suspected sighting of Mother with Father and F in the street near the family home. At the time there was lack of clarity about whether this was a formal request for police to undertake a welfare check. It was acknowledged within the Police report that: *it was social care's responsibility to do checks on the children, but given the history of repeated breaches of the restraining order and mother's apparent inability to cut contact with his father (which could be for many reasons), ...this should have been attended as a possible domestic.*

5.52 It would have been proportionate and understandable, given the information known about the volatile relationship between Father of F and Mother, had a formal request been made for the Police to support with a welfare check to confirm that F was not at immediate risk of domestic abuse between his parents. There are no service level agreements (SLAs) in place between the Police and Children's Social Care in relation to conducting welfare checks. Whilst it will be necessary to assess each case individually it would be helpful to have a clear process to request the support of the Police in undertaking welfare checks specifically when there are concerns of long term domestic abuse.

[19] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779401/Working_Together_to_Safeguard-Children.pdf

[20] The social worker had attempted an unannounced home visit

5.53 Adult mental health services were providing therapeutic support to Mother when CSC received additional reports regarding substance use and concerns about the wellbeing of Sibling 1 and F. The Mental Health Practitioner said that she was aware of issues regarding the punctuality of Sibling 1 at School and had talked with Mother about her responsibility to be better prepared however she did not know that other concerns had been raised. It was an omission that this information was not shared as it may have been helpful for the Mental Health Practitioner to have explored the issues with Mother.

5.54 Similarly, it could be argued that it would have been good practice had the Mental Health Practitioner shared information about Mothers concerns and anxieties regarding the separation from the Father of F. As agencies were not aware of this information it was not possible to offer Mother additional support and assistance as she worked to extract herself from this abusive relationship. The mental health practitioner reflected that there remains a lot of misunderstanding around mental health problems and if a parent has a mental health condition that does not mean they are unable to look after their children. It is possible that Mental Health practitioners may be reluctant to share information at times due to lack of confidence in how other agencies will respond to concerns which relate to parental mental health.

5.55 It was evident from discussion with Practitioners at the learning event that information sharing between CSC and Mental Health practitioners had historically been challenging. There was a culture in which services worked separately; information was not routinely shared Managers from Health who attended the learning event stated that: *there have been significant changes to practice as a result of this review and there is much more engagement between the STT and the safeguarding team.*

5.56 The CNWL Report noted that: *Once the case was closed to Social Care there appears to be an increase in the lack of engagement with Health Professionals. Whilst both the HV & Mental Health Practitioner have access to SystmOne records there is no record of either having communication with each other at any stage in the time leading up to the incident.* Had there been communication between these professionals it is possible that Mother's lack of engagement with the HV to arrange F's two year check and sporadic attendance and Mental Health Services may have prompted further exploration to identify if additional support was required by Mother. This was particularly important as the Child in Need Plan had been closed.

5.57 In January 2019 there was a near miss when F attended A and E for treatment to a head injury after falling out of his high chair. The attendance to UCC, MK was recorded on the health record (SystmOne), however, it was not flagged for the Health Visitor to follow up. It was an omission that the Health Visitor did not receive an alert about the incident and the opportunity to undertake further assessment and exploration to ensure that E was effectively safeguarded was missed.

5.58 Following closure of the second period of CiN and in the 12 months prior to the incident when F fell from the first floor bedroom window there were consistent referrals to CSC regarding the welfare of the children from School and anonymous members of the public. All referrals/contacts were responded to in isolation and there was little evidence of multi-agency discussion regarding cumulative concerns and the potential impact on the wellbeing of E and Sibling 1. For example, School raised concerns about Sibling 1 smelling of urine at school very shortly after the anonymous referral from a neighbour with concerns about neglect of the children. Whilst it was recorded that school were to monitor the situation there was lack of clarity about the expectations of school. Mother was regularly spoken to and it was recorded

that things improved for a period. It is not possible to have confidence, from information provided to this review that improvements were sustained and there was a positive impact on the lived experience of the children following the response by agencies to concerns.

5.59 Records indicated that whilst referrals were made to CSC there were occasions when this was logged as information received. The 2016 Triennial Review highlighted that many SCR's reviews indicated that information received by children's services was treated in one of two ways: as "information only", which is logged but not acted on; or as a formal referral.

> *There is an inherent danger in information that suggests potential child protection concerns being treated solely as information and logged without any further action (p168).*

5.60 CSC records in April and December 2018 indicate that there was a tendency to monitor and note that if further concerns were received an assessment would be completed. It appeared that each notification of concern was managed as a separate incident and, at times, closed before appropriate assessment and consideration had been given to the wellbeing of F and Sibling 1. Absence of a chronology and limitations in multi-agency information sharing were contributory factors which impacted on the effectiveness of holistic multi-agency consideration of safeguarding concerns.

Learning Point 9

It is important that practitioners use available systems and processes within and between agencies to share information about the wellbeing of children. Missed opportunities to share information can impact on the ability of practitioners to safeguard children

Learning Point 10

A clear process to request the assistance of the Police to complete welfare checks, particularly in cases where domestic abuse is known or suspected, will support partners to respond in a timely way when there are concerns about the welfare of a child

6 Good Practice

- In October 2017 The SW made significant efforts to involve agencies and the extended family particularly the Fathers of F and Sibling 1 in the CiN process.
- A family mapping took place to explore the case in depth prior to closure to CSC
- The HV shared information with the SW when a male was observed in the family home.
- Record of the Signs of Safety Mapping meeting and CiN closure meeting was stored on Mothers records. This was noted to be an example of excellent sharing of information
- Case closure in December 2017 was detailed and planned alongside involved professionals and the family

7 Conclusion

7.1 This review was triggered following the incident in which F fell out of his bedroom window and sustained potentially life threatening injuries. Prior to the incident there had been limited multi-agency involvement with the family and this review has considered two short periods when E and Sibling 1 were made subject to CiN plans.

7.2 There were at times significant efforts by agencies and practitioners to engage the family and utilise a structured problem solving approach to facilitate change. Whilst this appeared to be effective, and at times there was increased engagement, this was not sustained.

7.3 During the timeline of this review there were consistent concerns raised by members of the public regarding the welfare of the children, substance misuse and domestic abuse. The review has found that each incident appears to have been assessed individually and there was lack of holistic assessment to enable a clear and proportionate assessment of risk to inform decision making with regard to safeguarding the children.

7.4 Opportunities for multi agency practice improvement have been identified with regard to:

- Multi-agency response to domestic abuse, parental mental ill-health and substance misuse
- The CiN process
- Understanding the lived experience/voice of the child
- Multi-agency information sharing and response to concerns raised

7.5 Some of the findings in this review mirror those identified within the 2016 Ofsted report in which Milton Keynes was assessed as requiring improvement to be good. In addition, a report of the joint targeted area inspection[21] in December 2019 identified systemic shortcomings of relevance to this review which included: lack of managerial oversight within the school nursing service of children on child in need plans; limited multi agency coordination and integration of plans; lack of a clear and holistic picture of the complexity of children's lives within some agencies; insufficient coordination and responsiveness of interventions and limited evidence of escalation and challenge by agencies when outcomes for children are not improving.

7.6 Comprehensive multi-agency action plans were developed to implement findings from the inspections in 2016 and 2019 and recent CPSRs. There is a significant and wide-reaching improvement plan to address systemic issues and improve multi agency practice in Milton Keynes to safeguard children and young people. The improvement plan is monitored by the safeguarding partnership and a robust quality assurance programme is in place to evidence the impact of the improvement plan on the outcomes for children and young people.

7.7 There is a wide range of improvement activity currently underway that is of direct relevance to the findings in this review. In an effort to complement and strengthen ongoing work, and avoid duplication or repetition, this review will conclude with questions for the safeguarding partnership to obtain assurance that key learning points are effectively addressed rather than specific recommendations. There is commitment amongst the safeguarding partners to use learning from this review to improve multi-agency practice to safeguard children in Milton Keynes when there are concerns about domestic abuse, substance misuse and parental mental health.

8 Learning points and questions for the safeguarding partnership

Learning Point 1

When there are concerns about parental mental health, substance misuse and/or domestic abuse it is important that practitioners understand how these difficulties interact within the

[21] https://files.ofsted.gov.uk/v1/file/50134651

family and this information informs assessments and decisions to safeguard and reduce the negative impact on the children.

Learning Point 2

When there are concerns about parental mental health, substance misuse and/or domestic abuse, a holistic multi-agency assessment is required to consider historical information and provide clarity about outcomes and escalation should concerns persist, in order to prevent drift and provide adequate safeguards for children.

Learning Point 3

When parents are involved in mental health services it is important that there is transparency between practitioners and parents about information that will be shared with partner agencies, to inform the provision of support and intervention to safeguard children.

Learning Point 4

The lived experience of children and young people will improve when multi-agency CiN plans are child focussed with clear actions and measurable timely outcomes.

Learning Point 5

It is important that there is a shared understanding between agencies and the family about the roles and responsibilities of practitioners to implement the CiN plan, with specific focus and clarity about the provision of support on closure to monitor progress and sustain change.

Learning Point 6

Effective multi agency information sharing regarding the risks and vulnerabilities of children and young people should inform assessments and decisions regarding the provision of support and intervention and prevent drift and delay in meeting their needs.

Learning Point 7

It is insufficient to record concerns about school attendance, personal hygiene and the general well-being of children, it is important that appropriate tools are used to monitor and assess whether unmet needs and vulnerabilities are risk factors for neglect.

Learning Point 8

It is important that professionals are supported to critically reflect on observations of children and young people to further understanding their lived experience, and identify support to improve the wellbeing of children and young people particularly when there are concerns regarding neglect.

Learning Point 9

It is important that practitioners use available systems and processes within and between agencies to share information about the wellbeing of children. Missed opportunities to share information can impact on the ability of practitioners to safeguard children.

Learning Point 10

A clear process to request the assistance of the Police to complete welfare checks, particularly in cases where domestic abuse is known or suspected, will support partners to respond in a timely way when there are concerns about the welfare of a child.

Question for the safeguarding partnership

How can the safeguarding partnership obtain assurance from all partner agencies that key learning from this review is effectively addressed within multi agency improvement plans and that actions have a positive impact on the lives of children and young people? With a specific focus on:

- Professional understanding of how parental mental ill-health, substance misuse and/or domestic abuse interact and impact on children and families
- Holistic multi-agency assessments with analysis of historical information
- Information sharing between agencies, especially adult mental health and children's services
- Professional understanding of lived experience of the child and how this impacts on practice
- The CiN process, clarity of plans and robust arrangements on closure
- Monitoring of concerns about children and young people raised by the public and other agencies – provision of a proportionate response with recorded outcomes
- Clear procedure regarding welfare checks particularly when domestic abuse is a factor