Blackburn with Darwen, Blackpool and Lancashire
Children's Safeguarding Assurance Partnership

Local Child Safeguarding Practice Review

Ryan, Nathan and Amelia

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1. Introduction

1.1 The purpose of this Local Child Safeguarding Practice Review (LCSPR) is to identify learning - with which to improve practice - from how partner agencies in a Council within the Children's Safeguarding Assurance Partnership (CSAP) area worked individually and collectively to safeguard three siblings from harm over a period of several years during which there were continuing concerns about their mother's capacity to parent them. The children will be referred to in this report as Ryan, Nathan and Amelia which are not their real names. Two of the children had substantial additional needs (Ryan and Nathan). This report is an executive summary of the full LCSPR report.

1.2 CSAP decided to review this case after concerns were raised by Ofsted following an inspection of Children's Home 1. Ofsted expressed concern that the short breaks provided to Ryan and Nathan by Children's Home 1 were principally to enable mother to benefit from respite rather than meet the children's individual needs. On further examination, Ofsted expressed concern about the response of partner agencies to the risks which Nathan presented to Amelia. The Safeguarding Partners commissioned David Mellor, a retired chief officer of police with eight years' experience of conducting statutory reviews and no connection to local services to be the lead reviewer.

2. Terms of Reference and Methodology

2.1 The period covered by the review is from April 2016, when child protection planning began for Ryan and Nathan until 31st December 2019, by which time Nathan had been accommodated by the local authority. Significant events which took place prior to April 2016 are also included.

2.2 The key lines of enquiry for the review are:

- How effective was Child Protection Planning (April 2016 – January 2017). Was a pre-birth assessment considered in respect of Amelia (born in August 2016)?
- How effective was Child in Need support?
- To what extent was Child Protection and Child in Need planning integrated with other plans such as Education, Health and Care plans?
- How effective and inclusive was multi-agency working?
- How holistic were assessments of the needs of the family? Were the needs of each child considered? Was the impact of the needs of each child on their siblings considered? Was mother's parenting capacity fully considered?
- What action was taken when it became apparent that things were not improving for the children despite significant agency involvement?

- How responsive were agencies when concerns in respect of the family began to escalate?

- To what extent did agencies involved in providing support to the family maintain a focus on safeguarding the children from abuse and/or neglect?

- How effectively did agencies respond to mother's needs?

- How effectively did agencies respond to indications of disengagement and denial of access from mother?

- Did agencies gain a sufficient understanding of the 'lived experience' of the children.

- Did agencies meet the needs of the children at the appropriate level of need (the thresholds in place at the time).

- To what extent did agencies adopt a 'Think Family' or 'Whole Family' approach?

- To what extent did agencies understand the support provided by the wider family and consider the impact of the death of a key family member?

2.3 Agencies which had relevant contact with the family provided chronologies of that contact. A practitioner learning event was arranged to inform this review, which was attended by the following agencies:

- Teaching Hospitals NHS Foundation Trust (Health Visitor, CAMHS and School Nurse)
- Council Safeguarding Children with Complex Needs Team (Service Manager and Team Manager)
- GP Practice 2 (Practice Manager)
- Special School attended by Ryan and Nathan (Head Teacher)
- Special Educational Needs and Disability (SEND) Officer
- Nursery 1 (Manager)
- Nursery 2 (Proprietor/Manager)
- Children with disabilities charity (Family Support Manager)

Children's Home 1 (short breaks provider to Ryan and Nathan) was invited but did not attend.

2.4 The lead reviewer was also provided with copies of plans and key documents.

2.5 The mother and maternal grandmother of the children contributed to this review by commenting on a late draft of the report. Their views are shown in Section 5 of the report.

2.6 Further information on the process followed by the Children's Safeguarding Assurance Partnership in deciding how LCSPRs should be conducted can be found at https://www.proceduresonline.com/resources/sgp/p_child_sg_review.html

3. Brief summary of the case

Background

3.1 Mother, Ryan and Nathan moved to the Council area from another local authority area in 2009. The move appears to have been made to be near the support of maternal grandparents who were already resident in the Council area and because mother felt that her children's additional needs would be met more effectively in the Council area. Ryan and Nathan had been subject of child protection planning on the ground of neglect whilst living in the original local authority.

3.2 Ryan was born in 2004 and had global development delay, moderate learning disability and autistic traits. His school regarded him as very able. Nathan was born in 2007 and was autistic, had severe learning disability and was largely non-verbal. Mother has a self-disclosed slight learning difficulty and experienced low mood. She has also disclosed sexual assault and domestic abuse which is likely to have impacted on her wellbeing.

3.3 Following their move to the Council area, children's social care carried out three separate core assessment of Ryan and Nathan between 2010 and 2013, all of which led to Child in Need plans which were later closed due to non-engagement from mother or a retraction of consent. However, the children have been open to children's social care on either child protection, child in need or short breaks plans since November 2013.

3.4 Amelia was born in 2016. All three children have different fathers, none of whom appear to have played a significant role in the life of their children.

3.5 When mother became pregnant with Amelia, she and the two older siblings were living in a home supplied by, and in close proximity to, a local charity which provides support to children with disabilities and their families. The charity was mother's landlord and also provided her and the children with informal support. Mother also volunteered for the charity. In April 2016 a worker from the charity contacted the police after finding Ryan and Nathan alone in their home. They were locked in the property and had no means of contacting anyone and no access to food or drink. The kitchen was described as being in a 'poor state'. Mother was later arrested by the police and disclosed that she was experiencing difficulties in parenting Nathan because of his violence towards her and Ryan. Ryan and Nathan were placed on child protection plans under the category of neglect. A child and family assessment (CAFA) was completed but no pre-birth assessment was carried out in respect of the unborn Amelia, who was also made subject to child protection planning when born in August 2016.

3.6 The children were stepped down to child in need support in January 2017. Mother was said to have engaged well with children's social care and improvements had been made to the home with the input of intensive support from a social work assistant.

3.7 In June 2017 Ryan was referred to CAMHS by the special school he and Nathan attended. The school was concerned that there had been a decline in terms of Ryan's mood, self-harming, anger, obsessional behaviour and a refusal to follow instructions. In addition, a key family member had died a few months earlier.

3.8 In September 2017 mother made the first of several requests for Nathan to be accommodated by the local authority. A CAFA completed at that time found that Ryan often protected mother and Amelia from what was described as Nathan's 'aggressive' behaviour, which could lead to Ryan becoming frustrated, upset, anxious and engage in self-harming behaviour. In response it was decided that a provider of support to children with Autism Spectrum Disorder (ASD) would continue to provide support to both Ryan and Nathan but that this would now be provided separately.

3.9 In June 2018 Ryan disclosed to his school that he had been left on his own with his siblings and administered his own medication. However, children's social care decided to take no further action after mother said that Ryan's disclosures were untrue and the child declined to repeat them to a social worker.

3.10 When Amelia started at Nursery 1 in September 2018, concerns arose over an apparent development delay of 12-15 months and the fact that she was fed only pureed food by mother. A health visitor became involved but mother declined home visits from that service.

3.11 Ryan's school expressed concerns over his behaviour following his return to school in September 2018, particularly his adoption of the persona of a man of 75. In March 2019 he was assessed by a clinical psychologist who made a number of recommendations of how best to respond to Ryan's presentation, in particular to explore the underlying need which adopting the persona was serving.

3.12 Concerns about Amelia's delayed development continued in early 2019, including information that the child (now approaching two and a half years of age) was spending a lot of time in a pram at home. Later in the year mother disclosed that she locked Amelia in her bedroom at night to keep her safe from Nathan.

3.13 In April 2019 the charity from which mother rented the home in which she and the children lived, used their powers as landlord to gain entry to the home after a period during which they had been denied access. The home conditions gave considerable cause for concern.

3.14 In June 2019 a CAFA was completed which concluded that the current high level of short breaks should continue for Ryan and Nathan and a child in need plan should be put in place to support mother's parenting of Ryan and Nathan.

3.15 Concerns about the safety of the children within the family home began to accumulate from August 2019. Emergency respite was arranged for Nathan who was reported to be violent towards mother and Amelia. Mother moved Amelia from Nursery 1 to Nursery 2 in circumstances which raised concern that the move may have been motivated to evade scrutiny of Amelia.

3.16 From September 2019 the school became increasingly concerned about Ryan's agitated and distressed presentation. He was excluded from school the following month after threatening a teacher with a butter knife. He continued to self-harm, including attempting to drown himself.

3.17 In November 2019 all three children were made subject to a child protection plan on the grounds of neglect. The family had been receiving intensive support from a number of agencies but no improvements had been achieved. Partner agencies expressed concern that the level of violence in the family home necessitated the children being placed in the care of the local authority. This led the Child Protection Chair to invoke the Council area's Children's Safeguarding Quality Review (SQR) Service Issue Resolution Procedure, the outcome of which was that assessments of mother and maternal grandmother needed to be completed thoroughly and that the Core Group needed to be promptly reconvened to develop a safety plan whilst the assessments were completed.

3.18 Also during November 2019 Ofsted inspected Children's Home 1, which provided short breaks to Ryan and Nathan. Ofsted expressed concern that the short breaks were primarily to allow mother respite rather than to meet the individual needs of the children and when family circumstances were further enquired into, Ofsted took the view that the risks to Amelia from her siblings had not received a sufficient response. These issues were escalated to the Director of Children's Services.

3.19 A Legal Planning meeting agreed that the legal threshold for care proceedings had been met although the outcome of the subsequent Public Law Outline meeting was unclear.

3.20 On 13th December 2019 the Assistant Director, Children's Services and members of the Care Planning Panel agreed to issue proceedings and request accommodation of the children under Section 20 of the Children Act in the interim. After it did not prove possible to place the children with maternal grandmother, who had significant existing caring responsibilities, mother signed a Section 20 agreement for Nathan but refused to do so for Ryan and Amelia and so they remained in her care at that time.

4.0 Analysis

Each of the key lines of enquiry are addressed in this section of the report.

How effective was Child Protection Planning (April 2016 – January 2017). Was a pre-birth assessment considered in respect of Amelia (born in August 2016)?

4.1 Child protection planning was initiated after mother left Ryan and Nathan (aged 11 and 9 respectively) alone in the family's home whilst visiting her boyfriend in a local bar. The children had been locked in their home with no means of contacting anyone and no access to food or drink. The kitchen was noted to be dirty, the home untidy and cluttered and there was excrement in Nathan's room.

4.2 A CAFA was completed but no pre-birth assessment was conducted in respect of Amelia who was born 4 months later. The CAFA stated that it was being completed in line with a pre-birth assessment, although the impact of Amelia's birth on the family was only briefly referred to. The Pan-Lancashire Multi-Agency Pre-Birth Protocol (1) (this current protocol differs slightly from the protocol in place at that time) sets out the following non-exhaustive list of examples of when a multi-agency pre-birth assessment, led by children's social care, should be conducted:

- There are concerns that their parent, their partner or a potential carer may pose a risk to children – mother presented a risk of neglect to Amelia. There were concerns about Amelia's father's police record although he was later discharged by 'probation' who did not 'deem him to be a risk'. However, no police checks on Amelia's father were completed to inform the CAFA.

- There are concerns regarding the parent, their partner or a potential carer in terms of parenting capacity. Such concerns may include mental health problems, learning disability or inability to parent or protect children from harm – mother had neglected Ryan and Nathan and disclosed that she had experienced difficulties in parenting Ryan and particularly Nathan and was 'extremely stressed'. She self-disclosed having a slight learning difficulty.

- The parent, their partner or potential carer has children that have been made subject to a Child Protection Plan, or Care or Supervision Order at any time in the past, or if proceedings are ongoing – Ryan and Nathan were subject to a child protection plan under the category of neglect from 3 months prior to the birth of Amelia until 5 months after her birth.

- There are concerns regarding domestic abuse. These could relate to any person who may be involved with the unborn baby – Amelia's mother was the victim of domestic abuse from the child's father.

- There are concerns regarding problematic drug or alcohol misuse of the parent, their partner or a potential carer – when arrested by the police for neglect, mother was 'under the influence of alcohol'. It is unclear whether her use of alcohol was otherwise problematic.

- There are significant concerns about the lifestyle of parent, their partner or a potential carer which would impact on their ability to parent or protect children – mother had planned to go out on the Saturday following the neglect incident and leave the children in the care of her sister who had mental health issues.

- Concealed pregnancy or delayed presentation to ante-natal services – this example did not apply to this case.

4.3 Amelia was added to the child protection plan when she was born. It is possible that children's services took the view that this action precluded the need for a pre-birth assessment. However, application of the current Pan-Lancashire Protocol suggests that there were strong grounds for completing a pre-birth assessment. Mother was clearly struggling with the demands of parenting Ryan and Nathan. The arrival of a third child seemed likely to increase the demands upon her and impact upon the care she was able to provide to Ryan and Nathan. Arguably, the decision not to conduct a pre-birth assessment was the beginning of a pronounced tendency for Amelia's needs to be overshadowed by the needs of her elder siblings.

4.4 Child protection planning continued until all three children were stepped down to support as children in need in January 2017. The Review Child Protection Report, which informed the decision to step down from child protection planning, concluded that mother had worked with children's social care to improve her parenting and the family's home conditions and there were currently no concerns about mother meeting the needs of the children. The report has been shared with this review and progress is evidenced to a degree although many concerns remained, particularly in respect of mother's approach to boundaries and routines which she stated Ryan and Nathan were unable to adhere to because of their additional needs, Ryan's access to inappropriate adult material from the internet and home conditions, which were said to have improved, but on the most recent home visit documented – which was six months earlier - piles of clothing had been seen on the landing, in the lounge and on mother's bed, Nathan's room had smelled of faeces and Ryan's bed had lacked bedding. Nathan's challenging presentation when agitated was said to have become more pronounced recently and although mother was said to ensure the safety of Amelia when Nathan was 'being violent' there was no description of how she kept Amelia safe. Mother's cognitive abilities went largely unexplored. It was said that she had reported learning difficulties which had impacted upon her at school but that she felt that she coped well as an adult and did not feel that she required additional support.

4.5 Additionally, this review has been advised of concerns which were not referred to in the Review Child Protection Report, specifically Amelia being left alone with Ryan whilst mother answered the door, Ryan picking up Amelia when mother was not present to supervise,

mother's lack of insight into Ryan's continence issues, mother not bringing Amelia to the GP practice for her 8 week check, although this was rectified the following month and one failed visit by the health visitor. This review has been advised that the health visitor achieved only one home visit following the birth of Amelia.

Recommendation 1 (Pre-Birth Assessments)

That the Blackburn with Darwen, Blackpool and Lancashire Children's Safeguarding Assurance Partnership obtains assurance that pre-birth assessments are conducted in compliance with the Pan-Lancashire Protocol and that the fact that elder sibling(s) are currently subject to child protection or child in need planning – which could encompass the needs of the unborn child - is not regarded as a reason for ruling out a pre-birth assessment.

To what extent did agencies involved in providing support to the family maintain a focus on safeguarding the children from abuse and/or neglect?

4.6 In addressing this question it is important to recognise that in their 2018 inspection of the Council area's children's social care services, Ofsted found 'longstanding and widespread failures in the quality of social work practice' which meant that 'many children were not having their needs responded to in the right way or at the right time'. Ofsted went on to state that 'as a result, some children live in situations of chronic neglect for long periods of time. Their situations do not always improve and, for many, they deteriorate, resulting in poor outcomes and increased risk. For some children, the impact is serious, with children suffering additional harm that affects their health and development'. In this case, all three children experienced long periods of chronic neglect and Amelia in particular was exposed to physical abuse for a lengthy period despite substantial involvement of agencies including child protection and child in need planning.

4.7 The family dynamic of Nathan presenting a physical risk to Amelia and Ryan perceiving himself to be the 'protector' of his mother and sister, and Ryan suffering anxiety and engaging in self-harming behaviours as a result, was first recognised in the CAFA completed on 12th September 2017. However, the manager who endorsed the CAFA remarked that the assessment had disclosed 'no safeguarding issues'.

4.8 The same dynamic was disclosed by mother in a child in need meeting in April 2019 and Ryan's perceived role as his mother's protector from Nathan was noted in the clinical psychologist's report completed in March 2019. A CAFA completed in May 2019 noted that mother reported that Amelia's crying upset Nathan, causing him to have a 'melt-down' and try to 'get to' Amelia, although this issue was not included in a summary of 'needs and risks' for each child towards the end of the CAFA. Although the focus of the assessment was primarily on Ryan and Nathan, the risk that Nathan was stated to present to Amelia could have been included in the summary of risks. Again the CAFA concluded that 'no significant concerns were raised during this assessment period'.

4.9 It is unclear why the risks Nathan presented to Amelia went repeatedly unrecognised as a safeguarding concern during assessments. At the practitioner learning event it was suggested that the social workers in the children with complex needs team had a high level of expertise in assessing the additional needs of children but were less well equipped to identify safeguarding issues. Additionally, this team was managed by the Special Educational Needs and Disability (SEND) service until late 2019, at which time they were brought under the management of children's social care, partly to ensure a stronger focus on safeguarding. However, not recognising safeguarding concerns in respect of children with additional needs appears to be a sector wide problem. A 2016 report of the National Working Group on Safeguarding Disabled Children emphasised the need to ensure that practitioners have enough of an understanding of child protection issues for disabled children, understand the increased vulnerability of disabled children and take timely and effective action (3). At the practitioner learning event it was also suggested that substantial caseloads may have been a factor in safeguarding issues being overlooked.

4.10 Safeguarding concerns began to escalate from the beginning of August 2019 when over three consecutive days mother informed Children's Home 1 that Nathan had hit her with a paperweight and also hit his two siblings - although reference to the paperweight was omitted from the information shared with children's social care; CAMHS informed children's social care that Nathan was kicking and grabbing Amelia and that Ryan's mental health had deteriorated and he was saying that he would cut himself; and mother phoned EDT in distress to express fear of Nathan for herself and her other children. On Nathan's return from two days emergency respite at Children's Home 1, mother phoned children's social care to say that he was hitting her and she needed support from staff the children with disabilities charity to restrain him.

4.11 Further support was provided to mother and the children over the summer holiday period but concerns continued to be raised. On 10th September 2019 the case was discussed by the social worker and her team manager in supervision and the latter felt that the threshold for child protection planning had not been met at that time. Children's social care has advised this review that application of the continuum of need was not consistent in this case, and that the evidence available to the above supervision meeting clearly identified that the threshold for child protection had been met at least for Amelia.

4.12 Later the same month mother reported that Nathan had struck Amelia on the head and the social worker advised her team manager that she had to physically restrain Nathan twice to protect others in the family home during a visit. Children's Home 1 documented that the social worker told them that Nathan had pulled out a clump of Amelia's hair. Nathan was then placed with Children's Home 1 for 17 days to reduce the risks in the family home before matters appeared to come to a head at the 4th November 2019 ICPC at which all three children were made subject to a child protection plan on the ground of neglect. At this meeting several agencies expressed concerns that the children were no longer safe in their family home. As a result, the Child Protection Chair who had chaired the ICPC invoked the Council area's Child Protection Quality Review Service Issue Resolution Procedure. However, although the procedure was followed, the resolution was insufficiently speedy (12 working

days) and the resolution was overly optimistic in that it appeared to be predicated on the assumption that maternal grandmother could care for Nathan whilst assessments were carried out (Maternal grandmother had significant caring responsibilities herself). Nor was the resolution fully actioned in that the Core Group was not brought back together by the social worker the following week to develop a safety plan. The Core Group do not appear to have met until their next scheduled meeting date over two weeks later.

4.13 Despite the serious concerns expressed at the 4th November 2019 ICPC and the invoking of the Issue Resolution Procedure, urgent action to safeguard the children was not taken and undue faith appears to have been placed in the child protection plan to keep the children safe. Although a legal planning meeting took place on 25th November 2019 at which it was decided to seek care orders, at a public law outline meeting a week later no schedule of expectations had been prepared for mother.

4.14 Ofsted escalated concerns about the children to the Director of Children's Services following their 13th/14th November 2019 inspection of Children's Home 1 and Nathan was accommodated under Section 20. This method of escalation – via the external regulator to senior management – appeared to be more effective at generating a decisive response than the concerns expressed by local partner agencies.

4.15 Ofsted's 2012 thematic survey report on protecting disabled children found that disabled children who were also identified as children in need often had unidentified child protection needs. It also found that the majority of the then Local Safeguarding Children Boards (LSCBs) and local authorities were not robustly assessing the quality of work to protect disabled children. Since the publication of the report, there has been no significant change to the proportion of disabled children with a child protection plan.

4.16 In this case there was such a strong focus on the additional needs of Ryan and Nathan and the support mother needed to parent them, that Amelia's needs were either overlooked, minimised or considered discretely from her siblings for a substantial period of time. Safeguarding concerns in respect of Ryan and Nathan were overlooked until they escalated significantly. The impact of the needs of the children on their siblings was not fully explored and the risks to the siblings from each other was explored even less fully. Additionally, there was an emphasis on preventing family breakdown at the expense of exploring and understanding the lived experience of the children, in particular Nathan who is largely unable to communicate verbally.

4.17 Whilst it is recognised that considerable change has taken place since this LCSPR was commissioned, including the transfer of the Safeguarding Children with Complex Needs team from the Special Educational Needs and Disability service to Children's Social Care, it is recommended that the Blackburn with Darwen, Blackpool and Lancashire Children's Safeguarding Assurance Partnership (CSAP) seeks assurance that the Safeguarding Children with Complex Needs team has both the skills to assess and meet the additional needs of children and has sufficient awareness of the general and particular vulnerability of children with additional needs to abuse and neglect.

Recommendation 2 (Safeguarding Children with Complex Needs)

That the Blackburn with Darwen, Blackpool and Lancashire Children's Safeguarding Assurance Partnership obtain assurance that the Safeguarding Children with Complex Needs team has both the skills to assess and meet the additional needs of children and has sufficient awareness of the general and particular vulnerability of children with additional needs to abuse and neglect.

4.18 The Panel of senior managers established to oversee this review emphasised the importance of professional challenge to the whole system for safeguarding children and felt that this had been lacking in this case and that when the challenge was made at the 4th November 2019 ICPC, the Issue Resolution Procedure did not succeed in escalating matters successfully. It was open to professionals to consider the Safeguarding Children Partnership's 'Resolving Professional Disagreements (Escalation and Conflict Resolution) Procedure which is a multi-agency process envisaging escalation through three stages to very senior levels of management within a maximum of 15 working days. It is unclear how frequently this Procedure is invoked. The lead reviewer has completed several reviews in which professional disagreements procedures could have been invoked but were not. The Panel felt that professionals need to have the confidence to challenge and also need to recognise that it is their personal responsibility to challenge. However, the Panel acknowledged that power was not evenly distributed within the whole system for safeguarding children and that professionals may be reticent about challenging decisions taken by children's social care. It was felt that children's social care needed to make it clear that they were open to challenge but also improve their explanation of the justification for their decisions so that professionals from other agencies could make a more informed decision over when a challenge was merited.

Suggestion 1 (Resolving Professional Disagreements)

CSAP may wish to consider how best to take the issue of resolving professional differences further. The Child Protection Issue Resolution Procedure appears to be a robust process if adhered to and has a series of steps for escalating matters although, on the evidence from this case, professionals may be reticent to push the challenge beyond the initial stages. The Partnership's Resolving Professional Agreements Procedure appears less robust and may need to be strengthened and given greater publicity.

4.19 Until safeguarding issues began to escalate in August 2019, concerns that Amelia was experiencing parental neglect appeared to be managed on a 'separate track' to the ongoing involvement of agencies with Ryan and Nathan. Agencies had begun to notice that Amelia was experiencing neglect only when she started at Nursery 1 shortly after her second birthday (September 2018) although the family GP had documented 'poor interaction' between mother and the child a year earlier.

4.20 Nursery 1 and the health visitor estimated a development delay of 12-15 months, noting that she had just started to walk and her limbs appeared weak and shaky when she did so. There were also concerns about her motor skills and it was noted that she ate only pureed food. A referral to children's social care appeared to be under consideration at this point but wasn't made, probably because the social worker for Ryan and Nathan contacted the nursery and during that conversation concerns were shared, including those of the social worker who had noticed Amelia's delayed development when visiting Ryan and Nathan.

4.21 Amelia was placed with nursery 1 for a year during which the nursery initiated the TAC process and made several referrals for support including Early Years SEND, speech and language therapy and the local child development centre. The nursery involved the health visitor in the case and worked hard to engage with mother, who would not allow the health visitor to visit the family home. However, concerns that Amelia was experiencing neglect increased and by January 2019 the nursery felt that her delayed development may be environmental as they understood Amelia to sleep in a pram at home and she was known to still be eating baby food at home in May 2019. The health visitor appropriately adjusted the level of service she provided to 'Universal Plus'. The nursery became aware of the risk of physical abuse to Amelia by July 2019 when mother disclosed that she locked her daughter in her bedroom at night to keep her safe from her siblings.

4.22 At this point a safeguarding referral could have been considered although the nursery did contact children's social care to share their concerns and were advised that Amelia was now subject to a child in need plan. However, the child in need plan initiated in July 2019 related only to Ryan and Nathan and no CAFA was carried out in respect of Amelia until 23rd August 2019. After concerns arose over the reasons why mother had decided to move Amelia to a different nursery (Nursery 2), extra time at nursery was authorised for Amelia at a child in need on 12th September 2019.

4.23 It is concerning that there appeared to be some reticence in formally escalating concerns that Amelia was being neglected. Appropriate referrals to support Amelia in overcoming her considerable developmental delay were made and discussions with children's social care took place, but concerns had been steadily accumulating about Amelia for over a year and a safeguarding referral could have been made at various points. The Council area's Neglect Strategy states that neglect is 'notoriously difficult to define' but in this case there seemed to be a reticence about naming 'neglect' as opposed to the use of less loaded terms such as 'delayed development.'

4.24 CSAP has adopted neglect as one of its three priority areas, although there remain three separate neglect strategies for each of the predecessor Local Safeguarding Children Board (LSCB) areas. This level of priority recognises that despite the potential level of harm for children who are neglected being well known, concerns about neglect do not always attract the same level of response as concerns about sexual and physical abuse. In practice neglect can be notoriously difficult to define and research shows that it often co-exists with other forms of abuse and adversity. Of particular relevance to this review, the identification of neglect, and the response to it, becomes harder where children with disabilities and/or

learning difficulties are involved due to the additional needs and risks associated with the disability/difficulty the child lives with. All three strategies include elements to develop the ability of practitioners to identify to, respond to and prevent neglect; with an emphasis on the need for early intervention before a time at which statutory safeguarding processes become necessary. This review has been advised that a significant ongoing training programme has been implemented in support of the strategies, including training in the use of the Graded Care Profile 2 which could help practitioners to 'name' neglect more objectively whilst also supporting families addressing the elements of neglect more readily.

Recommendation 3 (Neglect)

That when the Blackburn with Darwen, Blackpool and Lancashire Children's Safeguarding Assurance Partnership disseminates the learning from this review, the opportunity is taken to highlight the response to neglect in this case and further embed the Council area's Neglect Strategy and the use of the Graded Care Profile 2 in order to improve safeguarding practice around the identification and management of neglect.

How holistic were assessments of the needs of the family? Were the needs of each child considered? Was the impact of the needs of each child on their siblings considered?

Did agencies meet the needs of the children when they met the threshold for the appropriate level of need.

4.25 In Ofsted's 2012 thematic survey report on protecting disabled children they stated that the best assessments provided a very clear picture of the child, the family and the child's place within the family. The impact of the child's disabilities on the child, *siblings* and parents was described and assessed in detail, with good use of information and assessments from other involved professionals (3).

4.26 Assessments in this case largely focussed on the additional needs of Ryan and Nathan and the support mother needed to address those needs. The impact of the additional needs of Ryan and Nathan on each other, and in particular on Amelia, was largely overlooked for some considerable time. Assessments were also insufficiently informed by updated assessments of mother's parenting capacity which, had they been completed, would almost certainly have disclosed that concerns about her parenting remained largely unaddressed, leaving the children exposed to long term parental neglect. The Panel noted that assessments made no use of the Neglect Graded Care Profile – which is an evidence-based assessment tool that helps professionals measure the quality of care provided by a parent or carer in meeting their child's needs, particularly where there are concerns about neglect.

How effective was Child in Need support?

4.27 All three children were stepped down to child in need support from child protection planning in January 2017. Child in need support in respect of the concerns about parental neglect ended in April 2017 and thereafter Ryan and Nathan were subject to child in need

planning in respect of their additional needs until safeguarding concerns began to escalate in the summer of 2019.

4.28 The child in need support to Ryan and Nathan was fairly narrow in both focus and engagement of partner agencies and a manager from the children with complex needs service who has reviewed the child in need plans for Ryan, Nathan and other children with additional needs, expressed the view that the child in need review meetings were akin to 'little chats' between the social worker and mother and home visits amounted to a 'tick in the box' rather than a meaningful event. At the practitioner learning event, professionals from agencies such as the children's school and CAMHS stated that they had not been invited to participate in child in need planning. The Panel was advised that improving the professional support to children on child in need plans was a key priority in the Council area's Social Work Improvement Plan.

To what extent was Child Protection and Child in Need planning integrated with other plans such as Education, Health and Care plans?

4.29 The purpose of an education, health and care (EHC) plan is to identify educational, health and social needs and set out the additional support required to meet those needs (4).

4.30 The most recent EHC plan for Ryan was completed on 12th July 2016. Nathan's EHCP was completed on 3rd August 2017. Although the plans have been reviewed by their school on an annual basis, they have not been amended since that time. Therefore the plans do not reflect the substantial adversity both children experienced in the intervening years which affected their needs and the additional support required to meet those needs.

4.31 The SEND Code of Practice (2015), which provides statutory guidance for organisations which work with and support children and young people who have special educational needs or disabilities, states that EHC plans are not expected to be amended on a very frequent basis (5). However, the guidance goes on to state that an EHC plan may need to be amended at other times where, for example, there are changes in health or social care provision resulting from minor or specific changes in the child or young person's circumstances, but where a full review or re-assessment is not necessary (6). This review has been advised that complete re-assessments are rarely required.

4.32 However, Ryan's EHC plan should have been amended. In the reviews of Ryan's EHC plan carried out by his school in December 2018, November 2019 and January 2020, it was recommended that his EHC plan be amended but this did not happen. Although the question of whether Ryan's needs had changed went unanswered in the December 2018 review, the November 2019 review stated that his needs had changed, specifically his mental health which was described as 'severe', his toilet training and escalation of his behaviour. The November 2019 review also noted that Ryan's provision had changed to what was described as 1:1 support on an individualised timetable. Arguably, the need to update Ryan's EHC plan could have been identified earlier as his March 2018 EHC plan review noted that he had

begun self-harming at home and school when 'frustrated and cross' for approximately a year.

4.33 As stated, Nathan's EHC plan was written on 3rd August 2017. It was reviewed by Nathan's school in 2018, 2019 and January 2020. Both the 2019 and 2020 reviews recommended that his EHC plan should be amended but this did not happen.

4.34 The responsibility for considering the school's recommendations that Ryan and Nathan's EHC plans should be amended rests with the Council area's Special Educational Needs and Disability (SEND) service. The service decided to action the November 2019 recommendation to amend Ryan's EHC plan but at the time of writing this LCSPR report, this had not been accomplished. Where it is decided not to follow the recommendation to amend an EHC plan, it appears that the rationale for such a decision is not routinely documented by the local Council. The Head of the Council area's SEND service has advised this review that his service has experienced difficulties in completing and updating EHC plans due to staffing and recruitment issues, although he advised this review that the situation is now improving. The Panel which oversaw this review expressed surprise the review of the EHC plan of a child such as Ryan, whose needs had changed so significantly and whose case had been subject to such a degree of scrutiny during the past year, had not been prioritised.

4.35 Ryan's EHC plan made no reference to the child protection planning he had been subject to since 12th May 2016 (two months prior to the date on which the plan was written), although information gathering for the report appears to have primarily taken place during March 2016. The list of contributors to the EHC plan included Ryan's Children's Home 1 key worker but did not include his social worker from the children with complex needs team. Whilst the EHC plan template asks if the child is 'Looked After' it doesn't ask if the child is subject to a child protection plan. In Ryan's case, the plan inaccurately stated that there was 'no other social care support' for Ryan. Child in Need plans were appended to both Ryan and Nathan's EHC plans.

4.36 The Head of the Council area's SEND service has advised this review that they are not allowed to include the child's social care status in the EHC plan, other than recording that they are a looked after child, without the consent of the parent. The aforementioned SEND Code of Practice confirms this position by stating that the local authority may choose to specify other social care needs which are not linked to the child or young person's SEN or to a disability, which could include reference to any child in need or *child protection plan* which a child may have relating to other family issues such as *neglect.* The Code of Practice recognises that such an approach could help the child and their parents manage the different plans and bring greater co-ordination of services. Inclusion **must** (bold font used in Code of Practice) only be with the consent of the child and their parents (7). Elsewhere, the Code of Practice states that the EHC plan reviews should be synchronised with social care plan reviews, and **must** (bold font used in Code of Practice) always meet the needs of the individual child (8).

4.37 Therefore the Code of Practice emphasis on parental consent is not aligned with the accepted approach to consent in safeguarding children policy. CSAP guidance states that where a child is subject to statutory child protection, best practice is for information to be shared with informed and explicit consent (9). However, the guidance goes on to state that to overrule this requires a judgement by the practitioner (with appropriate managerial oversight) that seeking consent may place the child at risk or further risk of harm, prejudice the detection of crime, or lead to an unjustified delay in making enquiries. This lack of alignment of statutory processes is not in the best interests of the child and it would be helpful for those involved in writing EHC plans to be advised of the action to consider should a parent withhold consent to any reference to a child protection plan in an EHC plan. This issue is not addressed in the SEND Code of Practice.

4.38 In the case of Ryan's EHC plan, his social worker was not a contributor and so the opportunity to document that he was subject to child protection planning may have been missed as a result. However, the school appears to have been involved in the child protection plan, at least as a consultee. Generally, engagement of relevant professionals in the EHC plan and review process for both Ryan and Nathan does not appear to have been sufficiently comprehensive. Social workers and health practitioners from a range of disciples were involved only intermittently - either as attendees or as the providers of reports. The LCSPR Panel felt that the involvement of the specialist school nurse in the EHC planning process would be particularly beneficial as they could act as a 'bridge' between the EHC plan and any child protection or child in need plan. However, the Panel acknowledged that the school nurse service currently lacks the capacity to discharge all responsibilities which would benefit from school nurse involvement.

4.39 Additionally, the EHC plans and reviews placed responsibility on Ryan to address issues in respect of which he was experiencing parental neglect. For example, Ryan's 2016 EHC plan described very encouraging progress in his physical health, emotional wellbeing, positive behaviours, effort and achievement in class, creativity and literacy and relationships with other pupils, but went on to state that he was as yet unable to alert his mother to his toilet needs and wore nappies overnight. However, the plan noted that he was able to use the toilet at Children's Home 1 with the assistance of verbal prompts. Mother was stated to hope that the success in his toileting routine to transfer from school and Children's Home 1 to the home environment and later in the EHC plan it is stated that Ryan 'needs to establish a routine in relation to his personal care for when he is at home, as he does when he is in school or at Children's Home 1'.

4.40 The EHC plan did not appear to include any exploration of why toileting at home remained problematic or envisage that there might be a role for mother in making progress in this area. In the 2014 parenting assessment carried out by the Children with Complex Needs Team, mother contended that both Ryan and Nathan were unable to attempt toilet training 'due to their needs', despite the fact that, at that time, Ryan was sometimes able to use the toilet at school (Paragraph 4.45). It is also worthy of note that, in the year after the EHC plan was written, Ryan was discharged by the continence service because of the difficulty the service experienced in contacting mother to arrange appointments. The local

teaching hospital, which is the provider of the continence services intends to examine the process for discharging children from the service who have not been brought by their parent(s).

4.41 The EHC plan also stated that Ryan was to be responsible for 'establishing a healthy sleeping habit in order to remain as alert as he can during the day'. The aforementioned 2014 parenting assessment identified a clear lack of routines in the family home, including a lack of bed time routines which led to Ryan staying up late which affected the following day at school. He was also noted to watch unsuitable late night TV. When challenged about the lack of routines, mother said that she 'does not believe in routines; she does what makes her children happy' (Paragraph 4.45).

4.42 Ryan's EHC plans do not appear to have adopted a child-centric approach to a child aged 11 who was considered to be 3-5 years behind his chronological age in relation to his functioning. On the basis of this review, it would appear that where a child is suffering entrenched parental neglect, there is a substantial risk that his or her EHC plan may inadvertently reinforce, rather than alleviate that neglect.

4.43 The EHC plan for Nathan generally does not place responsibility on him to address issues in which parental neglect may have been a factor, possibly because his needs were greater than those of Ryan and therefore he needed higher levels of support to achieve outcomes.

4.44 Plans sometimes included important errors. Nathan's EHC plan, and subsequent reviews of the plan, frequently refer incorrectly to Nathan's parents in the plural and the 2017 EHC plan also incorrectly identified a key family member who had died earlier in the year. The special educational provision Nathan needed to achieve desired outcomes included nominating a named member of staff to establish strong functioning links with his family so that his learning could be supported consistently at home. It does not appear that these 'strong functioning links' included any home visits.

4.45 Ofsted's 2018/19 annual report commented that area SEND inspections showed a 'decidedly mixed picture', in which the most successful areas identified needs effectively, leaders had a strong understanding of the effectiveness of SEND arrangements, co-production was working well and area leaders jointly plan, commission and provide services that are responsive to the needs of children and young people with SEND and their families, and education, health and care professionals worked together in a joined-up way to improve outcomes for children with SEND. Ofsted's annual report went on to say, that in too many geographic areas, leaders did not understand children's education, health and care needs in enough depth and did not have sufficient insight into children's lived experiences (10). Those involved in writing Ryan and Nathan's EHC plans clearly did not have sufficient insight into the entrenched parental neglect they were experiencing.

4.46 The Head of the Council area's SEND service has advised this review that in addition to tacking delays in actioning amendments to EHC plans, a new EHC plan Quality Framework

has been introduced, at the heart of which is a comprehensive programme for the auditing of plans. This is a very welcome development as is the plan to involve the Council for Disabled Children in providing training in the writing of EHC plan outcomes. Additionally, this review has been advised that Child Protection Chairs now have access to the SEND system and that there is a record of every child with an EHC plan on the children's social care system.

Recommendation 4 (Education, Health and Care Plans)

That the Blackburn with Darwen, Blackpool and Lancashire Children's Safeguarding Assurance Partnership obtains assurance in respect of the following education, health and care plan issues, in order to improve safeguarding practice:

- *when a review of a child's EHC plan recommends amendment of the plan; decisions to amend the plan or not, the recording of the rationale for the decision and any amendments to the plan, are all completed within statutory timescales,*
- *that there is guidance on the process to follow if consent to include reference to a child protection plan in the EHC plan is refused by the parent or child,*
- *that there is a process for escalating concerns that relevant professionals are not engaging with the EHC planning and review processes,*
- *that EHC plans are written in a child-centric manner and professionals writing the plans fully explore the lived experience of the child, and*
- *that Child Protection Chairs routinely check whether the child has an EHC plan.*

Was mother's parenting capacity fully considered?

4.47 One parenting assessment of mother was carried out. It was completed in 2014 at a time when she was parenting Ryan and Nathan who were aged 9 and 7 respectively. The 2014 parenting assessment – which was completed with very few sessions due to mother cancelling them - informed several subsequent assessments and plans and was not repeated or updated. CSAP's policy on social care assessments states that they should be seen as a continuing process rather than a single event.

4.48 The parenting assessment had been commissioned to gain more of an understanding of mother's parenting methods and the reasons why, historically she had not taken on board the support, advice and strategies suggested to her. The assessment was more successful in answering the first question, but less so the second question.

4.49 Mother was observed to show Ryan and Nathan care and attention and it was concluded that she clearly had a lot of love for them. She was said to have many strengths as a parent and very much valued her children as individuals, allowing them to make their own choices regularly.

4.50 However, the assessment identified a clear lack of routines in the family home which could impact on the children at times. For example a lack of bed time routines led to Ryan staying up late which affected the following day at school. He was also noted to watch

unsuitable late night TV. When challenged about the lack of routines, mother said that she 'does not believe in routines; she does what makes her children happy'. She also contended that Ryan and Nathan were unable to attempt toilet training 'due to their needs', despite the fact that Ryan was sometimes able to use the toilet at school. Nathan was noted to use a dummy and mother made no attempt to reduce his use of the dummy despite being advised of the potentially adverse impact on his speech and teeth. In not attempting to reduce Nathan's dummy use, there are similarities with the manner in which mother later parented Amelia, although it is accepted that Nathan had substantial additional needs.

4.51 At the time of the parenting assessment, Ryan and Nathan were noted to have separate bedrooms but slept on mattresses on the floor. Mother explained this by saying that the boys had broken numerous beds or destroyed them with smearing and she believed that it was better that they only sleep on mattresses 'for their own safety'.

4.52 Mother was said to have been reluctant to accept support from services in the past and talked very negatively about prior social care involvement. The assessment noted that this could suggest her previous experiences were preventing her from engaging with the current support being offered by the then children with disabilities team (CWDT) and the assessment recommended continuing to build a relationship with mother in order to encourage engagement in the future. Perhaps building a relationship assumed more importance than challenging unsatisfactory parenting and 'naming' neglect.

4.53 The parenting assessment concluded that further work needed to be offered to mother:

- to recognise the positives in her parenting. Once this had been effective, further support could be offered to build upon those positive foundations.

- to support her to develop and maintain routines

- around suitability of what Ryan and Nathan watched on TV and the internet

4.54 The extent to which these recommendations were actioned and what might have been the outcomes, is unclear. A key question is - what, if anything, changed in mother's parenting methods over the subsequent five years.

Recommendation 5 (Parenting Assessments)

That the Blackburn with Darwen, Blackpool and Lancashire Children's Safeguarding Assurance Partnership obtains assurance that practitioners update or repeat parenting assessments when circumstances change which should reflect the evidence of improvements or continuing or heightened concerns.

How effectively did agencies respond to mother's needs?

4.55 It needs to be acknowledged that parenting three children - two of whom had significant additional needs - as a single parent, was a hugely demanding task which would have dominated her life. Although mother had moved to the Council Area with Ryan and Nathan partly to be near her parents, the extent to which they could support her was affected by their own caring responsibilities. However, she did benefit from renting a home near the children with disabilities charity's premises and their staff often were her 'first port of call' when she needed support. Mother also benefitted from the support provided to Ryan and Nathan from Children's Home 1, the provider of support to children with ASD and the nursery provision for Amelia from her second birthday, which gradually increased to five days per week.

4.56 However, mother was noted by practitioners from a range of agencies to be struggling to cope with parenting the children. She disclosed she was 'extremely stressed' when seen by the Criminal Justice and Liaison Service following her arrest for neglecting Ryan and Nathan in April 2016. She was noted to be fatigued from caring for Ryan and Nathan by her GP in July 2017. She repeatedly began to request that Nathan be accommodated by the local authority from July 2017 and from the summer of 2019 frequently said that she was unable to cope or was at 'crisis point'.

4.57 Agencies provided mother with considerable support but sought to adopt a balanced approach which promoted resilience as opposed to encouraging dependence. However, mother appeared to be selective about the type of support she accepted or engaged with, persistently declining support to help her develop her parenting skills or try different parenting strategies for example.

4.58 Mother self-disclosed a slight learning difficulty and there were times when practitioners noted that she appeared to lack insight into the needs of her children and sometimes struggled to appreciate the variation between her perception of her child's abilities and what assessments disclosed. However, the 2014 parenting assessment did not consider mother's learning needs it was not until October 2019 that the social worker decided to seek advice about mother's cognitive ability and her capacity to change. It would have been of value to have explored this issue, had mother been willing to do so, at an earlier stage.

How effectively did agencies respond to indications of disengagement and denial of access from mother?

4.59 There is substantial evidence of a lack of co-operation with services by mother. She declined home visits by the health visitor when concerns arose about Amelia's delayed development in September 2018 and Amelia's health visitor from the postnatal period was able to gain access to the family home only on one occasion. The children with disabilities charity has advised this review that in April 2019 they were left with no alternative to using their powers as landlord to gain access to the home mother rented from them. It is unclear

for how long mother had been declining visits from workers from the charity. Mother declined an Early Help Assessment and initially refused to consent to a referral to the local child development centre for Amelia, although she later relented. Mother moved Amelia from nursery 1 to nursery 2 in August 2019. She gave different reasons for making this choice but her failure to disclose that agencies other than children with disabilities charity was involved with the family when she applied for a place at nursery 2, suggested that Amelia's best interests were not at the heart of her decision to change nursery provision.

4.60 Apart from the periods when her children were subject to child protection planning – May 2016 until January 2017 and from 4th November 2019 onwards, agencies were working with mother at level 2 or 3 on the continuum of need which required her consent. In these circumstances it was possible for mother to 'pick and choose' when to engage and with whom to engage. There is evidence that practitioners adopted a professionally assertive approach with mother at times. However, the strong emphasis on preventing family breakdown apparent in this case may have influenced practitioners to place a greater emphasis on support rather than challenge.

4.61 The Panel which oversaw this review expressed concern over the general lack of access to the family home by the health visitor following Amelia's birth and following the concerns raised by Nursery 1 two years later. The Panel emphasised the importance of health visitors needing to see where a child is sleeping. Whilst it was recognised that health visitors do not have a right of access, mother's persistent reluctance to admit the health visitor could have been escalated.

Dissemination of learning

Lack of access to the family home was an issue for a number of agencies including the children with complex needs team and the children with disabilities charity which prevented agencies fully appreciating the extent of the neglect the children were experiencing. When learning is disseminated from this review, this would be an appropriate message to highlight.

What action was taken when it became apparent that things were not improving for the children despite significant agency involvement?

4.62 The overriding emphasis in assessments and plans over the years was on 'preventing family breakdown'. The focus was therefore on providing sufficient support to enable the family unit to stay together even when it became apparent that not only were things not improving for the children but that there was a marked deterioration in their lived experience.

Did agencies gain a sufficient understanding of the 'lived experience' of the children.

4.63 The 'lived experience' is what a child sees, hears, thinks and experiences on a daily basis which impacts on their development and welfare. Practitioners need to actively hear what the child has to communicate, observe what they do in different contexts, hear what family members, significant adults/carers and professionals have said about the child, and think about history and context. Ultimately practitioners need to put themselves in that child's shoes and think 'what is life like for this child right now?'

4.64 Agencies did not gain sufficient insight into, and understanding of the 'lived experience' of the children. There was a strong emphasis on the needs of mother and providing her with support. Overall, there was a stronger focus on the additional needs of Ryan and Nathan whilst the needs of Amelia which were either overlooked or looked at discretely. Overall, the lived experience of the children was insufficiently explored and articulated.

4.65 All three children experienced chronic neglect over a prolonged period, which was periodically mitigated when agencies intervened and mother was supported to improve the children's living conditions for a time. For example the children with disabilities charity gained entry to the family's home in April 2019 and found it to be in an 'untidy and unclean' state, with a strong smell of urine and piles of rubbish, dirty laundry and general clutter throughout the property. Intense intervention was provided at that time to clean and clear the property involving several tip runs, the use of a skip and hours of cleaning and sorting. However, when supporting mother to clear Amelia's bedroom in October 2019 (six months after the first intervention), the charity found several bags of old, used and mouldy nappies.

4.66 The family's home had no access to an outdoor space and was close to a busy road which the children would have required adult supervision to negotiate. The children appear to have spent much of their non-school/nursery/short breaks time 'cooped up' in this home where there was a lack of stimulation and where they may also have become isolated.

4.67 A decline in Ryan's mood led to a referral to CAMHS by his school in June 2017. Self-harming behaviours including scratching his face and his arms and banging his head were noted by his school. He was also noted to be angry, presenting with obsessive behaviours and routines, disengaging in class and refusing to follow instructions. Concerns also began to emerge about his relationship with Nathan who he began referring to as 'Satan'.

4.68 From September 2017, Ryan appears to have begun perceiving himself as the 'protector' of his mother and Amelia – with whom he was noted to have a positive relationship - from Nathan's aggressive behaviour when agitated.

4.69 There is evidence that by June 2018, Ryan was being left to care for his siblings and administer his own medication whilst his mother was out of the home.

4.70 Ryan's continence needs were not consistently addressed and in October 2017 he was discharged from the continence service as a result of difficulty in contacting mother to arrange appointments.

4.71 Ryan was allowed to watch age inappropriate horror material. From September 2018 he began adopting the persona of an old man with cancer which led to a psychological assessment.

4.72 Ryan and Nathan began to access support from the provider of support to children with ASD separately from September 2017 which may have helped to reduce the tension between them.

4.73 Nathan has significantly greater additional needs than either of his siblings but it is difficult to gain insight into his lived experience from agency records. It is clear that mother increasingly struggled to cope with his presentation and the children with disabilities charity documented concerns that she had 'given up' on him. There may have been a tendency to over-focus on Nathan as the principle source of difficulty within the family leading to actions such as increasing use of Children's Home 1 for short breaks and eventually his accommodation by the local authority. The focus on Nathan's presentation may have distracted professionals from fully appreciating the chronic long term neglect experienced by all the children.

4.74 It is striking how often Nathan's presentation is described in terms of behaviour which professionals experienced difficulty in managing, rather than attempting to understand why he was presenting as he was. Additionally, in Nathan's EHCP and subsequent reviews, the 'child's perspective' appear to be limited to the teacher's observations of him in the school environment and the 'family's perspective' appears to be provided by mother and not always reflect the reality of his lived experience at that time. For example in the February 2019 EHCP review he was stated to be building better relationships with his siblings by mother, yet only two months later she advised a child in need meeting that she was unable to cope with Nathan's unpredictable behaviour towards herself and Amelia.

4.75 Nathan's tendency to try and 'lash out' at Amelia when she was crying may have arisen in part from his sensitivity to noise as he often wore ear defenders.

4.76 Amelia was left unsupervised, or supervised by Ryan from an early age. She entered the office of the children with disabilities charity alone on several occasions, requiring staff to return her to her home. In September 2016 concerns were expressed about Ryan being left alone to supervise his one month old sister.

4.77 Amelia experienced severe developmental delay, undeveloped motor skills and was fed mainly pureed food at home. Mother continued to have a large stock of baby food jars in the kitchen of their home for Amelia as late as October 2019 when she was over three years old. She appears to have continued to sleep in a pram long after this was appropriate and was locked in her bedroom by mother apparently to protect her from her

siblings. The children with disabilities charity noted that mother told them that she had put Amelia to bed at 3pm, 4pm or 5pm on a regular basis. Amelia appears to have experienced a distinct lack of stimulation and interaction within her home environment.

4.78 Amelia was clearly at risk from Nathan. Several incidents of violence from Nathan are noted in the chronology, including pulling out clumps of her hair on several occasions. The children with disabilities charity witnessed Amelia 'cowering, shaking and clinging on to mother's side' when Nathan was present.

4.79 There was a marked deterioration in Ryan's mental health over the two years prior to his brother being accommodated in December 2019 which was not fully documented in CAFAs and child in need plans for some of that time. As previously stated, it appears that CAMHS, who were providing support to Ryan are not normally contributors to child in need planning. At the learning event arranged to inform this review it was stated that, locally, there was a gap in services for children with a learning disability who experience mental health issues such as Ryan.

Suggestion 2 - Learning Disability Services for Children

As stated, at the learning event arranged to inform this review it was stated that, locally, there was a gap in services for children with a learning disability who experience mental health issues such as Ryan. It was not possible to explore this issue through this LCSPR but CSAP may wish to raise this with the commissioners of learning disability services.

To what extent did agencies understand the support provided by the wider family and consider the impact of the death of a key family member?

4.80 Generally, there appeared to be a good understanding of the support available to mother and her children from the maternal grandparents – and the limits on that support as a result of the maternal grandparent's caring responsibilities. The impact of the death of a key family member in early 2017 was considered by agencies, particularly the impact of bereavement on Ryan. However, as previously stated there appeared to be an assumption that maternal grandmother could care for Nathan whilst assessments were carried out following the invoking of the Issue Resolution Procedure in November 2019, which appears to have been overly optimistic.

4.81 There is no indication that agencies explored the potential for the involvement of the children's fathers in supporting the family until late in 2019. The fathers of Ryan and Nathan were believed to reside in the previous local authority area and Amelia's father appears to have been perceived as a risk to mother and the children for a time.

How effective and inclusive was multi-agency working?

4.82 This question has largely been addressed in answering earlier key lines of enquiry questions. The children with complex needs team were the lead service throughout and

their overriding priority of keeping the family together and their lack of focus on safeguarding concerns set an example which partner agencies did not begin to challenge until November 2019.

The role of the children with disabilities charity

4.83 A manager from the charity which provided support to mother and the children attended the practitioner learning event and made a helpful contribution. However, this review was only provided with a chronology by the charity as the LSCPR report was being finalised. The chronology provided much additional detail and further insight into the lived experience of the children.

4.84 The manager who attended that practitioner learning event felt that the charity was not commissioned, funded or equipped to provide the level of support that mother and the children needed. From the point at which mother first rented the home near the charity's premises, they effectively became 'first port of call' for mother. At that time the charity employed only two support workers on the premises who had limited capacity to respond to the family's needs.

4.85 Subsequently the charity was able to fund three family support workers and a manager from Big Lottery funding and thereafter were better equipped to offer support to mother and the children although, as before, they were not commissioned to do this. It is noticeable that the charity gradually became more active partners in working with agencies to support the family; they advocated for support for the family, prompted informal multi-agency discussions at times, and as concerns escalated from the summer of 2019, played a key role in attempts to prevent family breakdown.

4.86 However, relations between mother and the charity appear to have become strained for a time and workers from the charity were unable to gain access to the home. As stated earlier, the charity was forced to use its powers as a landlord to gain entry and the manager who attended the practitioner learning event described the home conditions she found when the charity was eventually able to gain entry as 'horrendous'. Although the charity provided mother with intense practical support to improve home conditions, there is no indication that they explicitly alerted partner agencies to this situation.

4.87 Looking back, the manager from the charity felt that it had never been appropriate for mother and the children to live near their premises. She added that the family's needs were 'way above' their remit, that all they were doing was 'firefighting' and that the charity's proximity to the family may have masked their true level of need from partner agencies for a time.

4.88 There would therefore be benefit in CSAP writing to the Chair of the charity to request that he reviews the support being provided to families to ensure that their safeguarding children policy and practice is robust, in particular partnership working and information

sharing with partner agencies. CSAP may also wish to consider how to gain similar assurance in respect of other local charities providing support to children and families.

Recommendation 6 (Role of the Children with Disabilities Charity)

That the Blackburn with Darwen, Blackpool and Lancashire Children's Safeguarding Assurance Partnership writes to the Chair of the children with disabilities charity to request that he reviews the support being provided to children and their families to ensure that the charity's safeguarding children policy and practice is robust, in particular partnership working and information sharing with partner agencies. The Partnership may also wish to consider how to gain similar assurance in respect of other local charities providing support to children and families.

Good Practice

4.85 The following good practice is noted in this case:

- Both Nursery 1 and Nursery 2 documented concerns in respect of Amelia and made many appropriate referrals to specialist services.

- Nursery 1 and Nursery 2 worked well together when mother initiated the transfer of Amelia from one nursery to another.

- The clinical psychology report on Ryan made several constructive recommendations to help practitioners respond to and seek to understand his adoption of the persona of an old man.

- Ofsted appropriately escalated concerns about the children to the Director of Children's Services following their November 2019 inspection of Children's Home 1.

5.0 Views of mother and maternal grandmother

5.1 Mother disagreed with much of the information agencies had recorded and shared with this review about her parenting. She also rejected the criticisms of her approach to parenting, stating that she did believe in boundaries and routines and that she implemented these consistently, citing the fact that the she always ensured the children were dressed and ready to go to school or nursery in the morning as an example. She said that it was untrue to say that Ryan stayed up late. She added that she couldn't recall the parenting assessment taking place.

5.2 It was clear that mother had read the CSPR report carefully and had made a note of all the issues with which she disagreed. The lead reviewer subsequently checked the various agency chronologies, minutes and assessments which he relied upon to draft the report and found that the points which mother disputed were clearly recorded in agency records.

5.3 Mother said that she was 'fed up' with the 'neglect' word being applied to her parenting. She said that she had told professionals that they wouldn't last ten minutes 'in her shoes', looking after her children. She added that lots of families struggle with a single child with additional needs, whereas she parented two. Looking back, she felt that she should have received more support particularly in parenting Nathan, adding that agencies were well aware of the difficulties she was experiencing in this regard but were slow to act.

5.4 Maternal grandmother also commented on the CSPR report. She said that her daughter had repeatedly begged the children with complex needs team for help which had been refused and that her daughter had been told that she should seek support from family and friends. Overall, she felt that if the right support had been provided earlier, then things would not have deteriorated so much. She felt that a key priority for her daughter had been keeping Amelia safe from Nathan for the first three years of her life, which had proved extremely challenging. She felt that her daughter had not been listened to and had not been given sufficient opportunity to demonstrate positive change.

5.5 Maternal grandmother also felt that the local authority's approach for her to look after Ryan and Amelia in December 2019 (Paragraph 3.20) had not been handled competently, with plans chopping and changing. She also said that she had been unaware of the proposal for her to care for Nathan whilst assessments were carried out in November 2019 (Paragraph 4.12).

List of Recommendations and Suggestions

Recommendation 1 (Pre-Birth Assessments)

That the Blackburn with Darwen, Blackpool and Lancashire Children's Safeguarding Assurance Partnership obtains assurance that pre-birth assessments are conducted in compliance with the Pan-Lancashire Protocol and that the fact that elder sibling(s) are currently subject to child protection or child in need planning – which could encompass the needs of the unborn child - is not regarded as a reason for ruling out a pre-birth assessment.

Recommendation 2 (Safeguarding Children with Complex Needs)

That the Blackburn with Darwen, Blackpool and Lancashire Children's Safeguarding Assurance Partnership obtain assurance that the Safeguarding Children with Complex Needs team has both the skills to assess and meet the additional needs of children and has sufficient awareness of the general and particular vulnerability of children with additional needs to abuse and neglect.

Recommendation 3 (Neglect)

That when the Blackburn with Darwen, Blackpool and Lancashire Children's Safeguarding Assurance Partnership disseminates the learning from this review, the opportunity is taken

to highlight the response to neglect in this case and further embed the Council area's Neglect Strategy and the use of the Graded Care Profile 2 in order to improve safeguarding practice around the identification and management of neglect.

Recommendation 4 (Education, Health and Care Plans)

That the Blackburn with Darwen, Blackpool and Lancashire Children's Safeguarding Assurance Partnership obtains assurance in respect of the following education, health and care plan issues, in order to improve safeguarding practice:

- *when a review of a child's EHC plan recommends amendment of the plan; decisions to amend the plan or not, the recording of the rationale for the decision and any amendments to the plan, are all completed within statutory timescales,*
- *that there is guidance on the process to follow if consent to include reference to a child protection plan in the EHC plan is refused by the parent or child,*
- *that there is a process for escalating concerns that relevant professionals are not engaging with the EHC planning and review processes,*
- *that EHC plans are written in a child-centric manner and professionals writing the plans fully explore the lived experience of the child, and*
- *that Child Protection Chairs routinely check whether the child has an EHC plan.*

Recommendation 5 (Parenting Assessments)

That the Blackburn with Darwen, Blackpool and Lancashire Children's Safeguarding Assurance Partnership obtains assurance that practitioners update or repeat parenting assessments when circumstances change which should reflect the evidence of improvements or continuing or heightened concerns.

Recommendation 6 (Role of the Children with Disabilities Charity)

That the Blackburn with Darwen, Blackpool and Lancashire Children's Safeguarding Assurance Partnership writes to the Chair of the children with disabilities charity to request that he reviews the support being provided to children and their families to ensure that the charity's safeguarding children policy and practice is robust, in particular partnership working and information sharing with partner agencies. The Partnership may also wish to consider how to gain similar assurance in respect of other local charities providing support to children and families.

Suggestion 1

CSAP may wish to consider how best to take the issue of resolving professional disagreements further. The Child Protection Issue Resolution Procedure appears to be a robust process if adhered to and has a series of steps for escalating matters although, on the evidence from this case, professionals may be reticent to push the challenge beyond the initial stages. The Partnership's Resolving Professional Agreements Procedure appears less robust and may need to be strengthened and given greater publicity.

Suggestion 2

At the learning event arranged to inform this review it was stated that, locally, there was a gap in services for children with a learning disability who experience mental health issues such as Ryan. It was not possible to explore this issue through this LCSPR but CSAP may wish to raise this with the commissioners of learning disability services.

Dissemination of learning

Lack of access to the family home was an issue for a number of agencies including the children with complex needs team and the children with disabilities charity which prevented agencies fully appreciating the extent of the neglect the children were experiencing. When learning is disseminated from this review, this would be an appropriate message to highlight.

References

(1) Retrieved from https://panlancashirescb.proceduresonline.com/pdfs/multi-agency_prebirth_protocol.pdf

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(3) Retrieved from https://www.gov.uk/government/publications/protecting-disabled-children-thematic-inspection

(4) Retrieved from https://www.gov.uk/children-with-special-educational-needs/extra-SEN-help

(5) Retrieved from https://www.gov.uk/government/publications/send-code-of-practice-0-to-25

(6) ibid

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(8) ibid

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(10) Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/859422/Annual_Report_of_Her_Majesty_s_Chief_Inspector_of_Education__Children_s_Services_and_Skills_201819.pdf